London Ambulance Service NHS Trust

MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD TO BE HELD IN PUBLIC ON TUESDAY 28 JANUARY 2020 AT 10:00-15:00 IN THE CONFERENCE ROOM, LONDON AMBULANCE SERVICE HQ, 220 WATERLOO ROAD, LONDON SE1 8SD

Agenda: Public session

Timing	Item	Ref.		Owner	Status Assurance Decision Discussion Information
10.00	**1.**	**TB/19/95** Oral	**Welcome and apologies** To welcome attendees and note any apologies received.	HL	Information
10.05	**2.**	**TB/19/96** Oral	**Declarations of interest** To request and record any notifications of declarations of interest in relation to today's agenda.	All	Assurance
10.10	**3.**	**TB/19/97** Attachment	**Minutes of the meeting held in public on 26 November 2019** To approve the minutes of the meeting held on 26 November 2019.	HL	Decision
	4.	**TB/19/98** Attachment	**Matters arising** To review the action schedule arising from previous meetings.	HL	Information
10.15	**5.**	**TB/19/99** Oral	**Board members' feedback** To receive information about Board members' activities since the last meeting.	All	Information
10.20	**6.**	**TB/19/100** Attachment	**Report from the Chair** To receive a report from the Chair.	HL	Information
10.30	**7.**	**TB/19/101** Attachment	**Report from the Chief Executive** To receive a report from the Chief Executive.	GE	Information
STRATEGY & PLANNING					
10.40	**8.**	**TB/19/102** Attachment	**London Ambulance Service NHS Trust – 3 year business planning** To receive an articulation of the Trust's approach to the development of its 3 Year Business Plan	RF	Discussion
11.00	**9.**	**TB/19/103** Attachment	**National Procurement of Double Crewed Ambulances** To agree the Trust's commitment to purchasing DCAs through the national procurement framework.	RF	Decision

Timing	Item	Ref.		Owner	Status Assurance Decision Discussion Information
QUALITY, PERFORMANCE AND ASSURANCE					
11.15	**10.**	**TB/19/104** Attachment (To follow) Attachment (To follow)	**Trust Board Committee Assurance Reports** To receive the reports of the Board Assurance Committee meetings that have taken place since the last meeting of the Board. **(i) Quality Assurance Committee meeting on 09 January 2020** **(ii) Logistics and Infrastructure Committee meeting on 14 January 2020** **(iii) People and Culture Committee meeting on 16 January 2020** **(iv) Finance and Investment Committee meeting on 21 January 2020**	 MS TdP JM FC	Assurance
12.00	**11.**	**TB/19/105** Attachment	**Board Assurance Framework and Corporate Risk Register** To receive the Board Assurance Framework and the Corporate Risk Register.	PH	Discussion
12.15	**12.**	**TB/19/106** Attachment	**Serious Incident Update** To note declared and closed Serious Incidents.	TB	Discussion
12.30	**13.**	**TB/19/107** Attachment	**CQC Report** To receive the report of the Care Quality Commission's most recent inspection of the Trust	TB	Assurance
12.45	**14.**	**TB/19/108** To follow	**Annual EPRR Assurance Assessment** To receive the outcome of the annual EPRR assurance assessment	KM	Assurance
BREAK					
GOVERNANCE					
13.30	**15.**	**TB/19/109** To follow	**Report of the Trust Secretary:** **(i) Use of Trust Seal** **(ii) Policies** **(iii) Terms of Reference** **(iv) Register of Interests**	PH	Decision
13.50	**16.**	**TB/19/110** Attachment	**Trust Board Forward Planner** To receive the Trust Board forward planner.	PH	Information
14.00	**17.**	**TB/19/111** Oral	**Questions from members of the public**	HL	Information

Timing	Item	Ref.		Owner	Status Assurance Decision Discussion Information
14.15	**18.**	**TB/19/112** Oral	**Any other business**	HL	Information
14.20	**19.**	**TB/19/113** Oral	**Review of the meeting** To consider: - Behaviours at the meeting. - Standard of papers submitted for Board consideration. - Standard of debate / challenge.	HL	Information
15.00	**20.**	**TB/19/114** Oral	**Meeting close** The meeting of the Trust Board in public closes.	HL	
	Date of next meeting: The date of the next Trust Board meeting in public is on Tuesday 31 March 2020 in the conference room, London Ambulance Service HQ, 220 Waterloo Road, London SE1 8SD.				

Additional reports, circulated for information only:

TB/19/115 Quality Report

TB/19/116 Integrated Quality & Performance Report

TB/19/117 Health and Safety Report

TB/19/118 Freedom to Speak Up quarterly report

TB/19/119 CARU Annual Reports

TB/19/120 Regulation 28; Prevention of Future Deaths Report arising from the inquests into the deaths of Xavier Thomas; Christine Archibald; James McMullan; Alexandre Pigeard; Kirsty Boden; Sébastien Bélanger; Sara Zelenak; and Ignacio Echeverria Miralles de Imperial – LAS Response

AC/19/66 Annual Review of Corporate Governance

London Ambulance Service NHS Trust

TRUST BOARD: Public meeting – Tuesday 26 November 2019

DRAFT Minutes of the public meeting of the Board held on 26 November 2019 at 10.00am, in the Conference Room, Headquarters, 220 Waterloo Road London SE1 8SD

Present		
Name	**Initials**	**Role**
Heather Lawrence	HL	Chair
Trisha Bain	TB	Chief Quality Officer
Lorraine Bewes	LB	Chief Finance Officer
Karim Brohi	KB	Non-Executive Director
Fergus Cass	FC	Non-Executive Director
Sheila Doyle	SD	Non-Executive Director
Garrett Emmerson	GE	Chief Executive Officer (CEO)
John Jones	JJ	Non-Executive Director
Jayne Mee	JM	Non-Executive Director (from item x)
Khadir Meer	KM	Chief Operating Officer
Theo de Pencier	TdP	Non-Executive Director
Mark Spencer	MS	Non-Executive Director (from item x)
Fenella Wrigley	FW	Chief Medical Officer
In attendance		
Ross Fullerton	RF	Director of Strategy, Technology and Development
Philippa Harding	PH	Director of Corporate Governance
Ali Layne-Smith	ALS	Director of People and Culture
Paul Woodrow	PW	Director (for item 16 only)
Melissa Berry	MB	Diversity Consultant (for items 14 and 15)
Katy Crichton	KC	Freedom to Speak Up Guardian (for item 17 only)
Victoria Moore	VM	Committee Services Officer

Four members of the public were in attendance at the meeting.

1. Welcome and apologies (TB/19/69)

1.1. The Chair welcomed all to the meeting.

1.2. The Chair noted apologies from Amit Khutti, Associate Non-Executive Director

1.3. The Chair informed Board members that Jayne Mee, Non-Executive Director and Mark Spencer, Non-Executive Director had given their apologies for joining the Board late.

2. Declarations of interest (TB/19/70)

2.1. There were no interests declared in any matter on the agenda.

3. Minutes of the meeting held in public on 24 September 2019 (TB/19/71)

3.1. The minutes of the meeting held in public on 24 September 2019 were approved as an accurate record of the meeting subject to the following amendments:

3.1.1. Minute reference TB/19/50, paragraph 6.2, the first sentence should be amended to read "The Board considered the Chair's meeting with Sir David Behan, Chair of Health Education England, raising awareness of two issues; the low number of paramedics from a black and minority ethnic (BAME) background and the issue of equality between Urgent Care Nurses and Paramedics."

3.1.2. Minute reference TB/19/55, paragraph 11.8, the first sentence should be amended to read "The report on the Losses and Special Payments was considered, noting the expenditure on vehicle accidents had indicated a reduction of £224k compared with the same period in the previous year although evidence indicated that the number of accidents was consistent with previous years."

3.1.3. Minute reference TB/19/59, paragraph 15.2, to be amended to read "The Board noted the high sickness rate of 5% related to musculoskeletal injuries absence. It was noted that risk assessments were being undertaken in response to incidents in London."

4. Matters Arising (TB/19/72)

4.1. The Board reviewed the action log, noting that one action had not been updated prior to the meeting. The Board requested further information. An oral update was provided with regard to action reference TB/19/51, stating that a larger piece of work was required to understand the modelling framework, the accuracies and inaccuracies and what needed to be delivered to resolve before the requested report could be presented.

5. Board Members' feedback (TB/19/73)

5.1. The Board received feedback from Non-Executive Directors relating to engagement activities that they had recently undertaken across the Trust.

5.2. John Jones (JJ), Non-Executive Director informed members that he had attended the Audit and Finance Forum on 22 October 2019, noting a presentation from Baroness Harding on the NHS People Plan and proposed changes to the way that money was distributed to NHS Trusts, emphasising the importance of having a sustainable and balanced plan.

5.3. Further to this members discussed Primary Care Networks (PCNs), their development and the inclusion of funding for paramedic resources in 2021/22. Members acknowledged that this could prove a significant challenge for Trust recruitment in the future.

6. Report from the Chair (TB/19/74)

6.1. The report from the Chair provided Board members with an overview of the meetings and events attended with external stakeholders of the service; the content was noted.

6.2. While at the NHS Providers Annual Conference, the Chair reported that she had attended a session on the Kark Report on the Fit and Proper Person Requirement; she noted the implications and requirements being placed on NHS trusts as a result. Links to the Fit and Proper Persons Policy that had been presented for approval elsewhere on the Board agenda (minute reference TB/19/87) were noted.

6.3. The Chair added that she had attended her first meeting as a Trustee of NHS Providers representing the ambulance sector and the main topics of discussion were winter planning and pensions.

6.4. The Chair acknowledged that it was the final formal Board meeting that John Jones (JJ), Non-Executive Director, would attend, as his term of office expired on 31 December 2019. She extended heartfelt thanks for the contribution he had made to the Trust Board, serving as a Non-Executive Director for two terms and for chairing the Audit Committee with expertise and a sense of calm at all times. All members of the Board thanked JJ for his contributions and wished him well for the future.

7. Report from the Chief Executive (TB/19/75)

7.1. Garrett Emmerson (GE) presented his report on progress and key issues, events and activities since the last formal Board meeting.

7.2. It was acknowledged that performance remained a challenge and this was aligned with the experience of the rest of the country. It was expected that winter planning would help to address these challenges, as the pressure increased over the winter period.

7.3. The Board received detail of the implementation of the restructure within the Emergency Operations Centre (EOC) and in the wider Operations directorate. It was noted that an improvement plan was in place to address the issues and challenges faced in the EOC. The Chair asked if the staff were aware of the action plans in place and for more information about what was being done to improve the position. There was reassurance that staff were aware of the plan, but only of the elements as they affected them; there was not a holistic awareness of the full action plan at all levels of the organisation. Work would be undertaken to improve this.

7.4. The North East London (NEL) 'Perfect Day' was a high profile event, which took place on 30 September 2019, and provided an opportunity to test the feasibility of London 999 and 111 integration by providing access to all existing services 'downstream'. The purpose of the Perfect Day was to see whether by providing responsive and appropriate urgent care services to the NEL population, Emergency Department attendances, London Ambulance Service NHS Trust (LAS) incidents and ambulance conveyances could be reduced and staff and patient experience improved. It tested the feasibility of integrating specific, high impact pathways as part of the journey to join up access to urgent and emergency care services. This included advanced paramedics, urgent care, mental health, physician response unit (PRU), easier access to GPs, falls and community pathways and support from end of life care services. Partners from across London, and the South Central Ambulance Service NHS Foundation Trust (SCAS), visited NEL during the event to see how the day was

delivered. The event delivered positive results and helped to demonstrate the strength and deliverability of the LAS strategy. This findings from the evaluation would also be used to inform and support winter planning.

7.5. Finally the Board discussed the impact of assaults on staff members and the Trust's response to these, including prosecutions. GE acknowledged the member of staff Lizzie Smith who had spoken publically about her experience to deter others who think that it is acceptable to abuse, assault or attack ambulance staff and expressed his hope that this had helped to raise awareness internally and in the media.

8. Patient and Public engagement (TB/19/76)

8.1 Anthony Tiernan (AT), Director of Communications and Engagement, introduced the proposed creation of a London Ambulance Service Public and Patient Council, (subject to engagement with stakeholders). He also highlighted the intention to investigate the feasibility of creating a London Ambulance Service youth forum and plans to develop a public and patient engagement strategy for March 2020.

8.2 Non-Executive Directors supported the principle of the proposals, concluding that it was the right direction of travel. Board members queried the membership and outline Terms of Reference, concluding that further work was required to ensure that these were fit for purpose. Key issues that were raised related to the importance of ensuring that the membership of the Council was appropriately representative, for example it should include the perspectives of those who were vulnerable and/or homeless, as well as other hard-to-reach groups. It was also important that the Council had an appropriately diverse membership, which did not necessarily view the LAS favourably, as challenge would be valuable in ensuring that the service provided by the Trust continued to improve. The assurance role of the Council required clarification, as did its potential duties.

ACTION: Anthony Tiernan (AT), Director of Communications and Engagement, to develop a more structured terms of reference for the Board to consider for co-production with stakeholders at the informal Board session 17 December 2019.

8.3 The proposal to investigate the feasibility of creating a London Ambulance Service Youth Forum was strongly supported by Non-Executive Directors. It was suggested that this work should start with an understanding of the work that Karim Brohi (KB), Non-Executive-Director, was already engaged in though his trauma surgery connections.

ACTION: Anthony Tiernan (AT), Director of Communications and Engagement, to engage with Karim Brohi (KB), Non-Executive-Director, on the feasibility of establishing a London Ambulance Service Youth Forum.

8.4 Two questions had been received from the Patient's Forum, which were answered by AT on behalf of the Board as follows:

"The LAS was one of the highest performing NHS Trusts in London in relation to patient and public involvement: it is now the lowest. What action will the Board take to restore the place of the LAS as a high performing Trust that actively listens to patients and the public and takes action to meet their needs and recommendations?"

8.4.1 "As you would expect, we can't agree with your proposition about how well we perform now compared to the past.

8.4.2 You'll know that I have recently taken on responsibility for public and patient involvement and as part of my handover from the Chief Quality Officer and Head of Patient Involvement it is clear that we have be active in our activities.

8.4.3 Over the last six months, this includes, for instance, dedicated initiatives which involved patients and the public in the development of our mental health joint response car, how we support patients at the end of their lives and the development of our maternity pioneer service. We have also run a pre-hospital emergency department data sharing project.

8.4.4 We also engage with patients and the public via the hundreds of public education events our staff take part in each year. Since April we have spoken to thousands of people at over 220 events.

8.4.5 Other examples of the way we engage include our recent Annual Public Meeting which was attended by over 140 patients and members of the public. Our live-stream of the event has been watched over 4,100 times.

8.4.6 In addition, we have continued to work closely with and support the LAS Patients' Forum. This includes supporting our staff to attend and speak at your events and meetings, providing briefings and information, and your direct involvement in developing service delivery, for instance, your work with the LAS Academy.

8.4.7 We also involve you in regular reviews of the way we respond to complaints and I have personally set up dedicated sessions so we can meet with the Patients' Forum. The next one is on 10 December.

8.4.8 Going forward, you will have seen from the public and patient engagement paper on today's agenda, that we are looking to – working with our partners – establish a Public and Patients Council which will help further enhance the way we involve patients and public. This is supported by our commissioners, North West London collaboration of clinical commissioning groups.

8.4.9 We will be engaging with public and patient groups on the development of the group over the next month, but the absolute focus for us is how we represent the diverse population that makes us London and hear as many voices as possible. This will include local Healthwatch, Age UK, Samaritans, Patients' Association, National Voices and many others.

8.4.10 In addition, we have committed to developing a new public and patient engagement strategy for the new financial year, replacing the current one.

8.4.11 We will also explore the possibility of setting up a Youth Forum, building on the successful work of many NHS trusts across the country."

"How can the Patient' Forum for the LAS help in the process of improvement?"

8.4.12 "We are committed to working closely with Patients' Forum and to involve you in the activity outlined above.

8.4.13 However, we need to ensure that we hear from a wide range of voices, which is why we have proposed the development of a Public and Patients Council."

9. Winter Preparedness (TB/19/77)

9.1 Khadir Meer (KM), Chief Operating Officer, presented the winter preparedness report which provided members with detail of the Trust's 2019/20 winter operating model, preparations for supporting the London urgent and emergency care system over winter, producing the levels of staffing required and ensuring required levels of performance are delivered over the winter months.

9.2 A key set of principles for adoption were outlined with a representation of process flow to ensure effective internal and external governance is followed and the links to the winter plan were clearly provided. Board members acknowledged the clarity of the presentation, considering the financial and staffing challenges faced by the Trust and the action plans in place to mitigate these. It was noted that a quality impact assessment of these plans would be presented to the Quality Assurance Committee in January 2020.

ACTION: KM to ensure that quality impact assessments of the plans in place to address the Trust's financial and staffing challenges are presented to the Quality Assurance Committee in January 2020.

9.3 It was noted that achievement of performance targets provided a greater challenge during the winter period; however there was a clear trajectory for delivery and expectation of actions to ensure this does not slip. Board members noted the importance of ensuring that the Trust's performance during this period was closely managed and requested regular updates on Trust performance to be provided to Board members during the winter period.

ACTION: KM to ensure that Board members receive regular updates on Trust performance during the winter period.

10. Board Committee Assurance Reports (TB/19/78)

(i) Quality Assurance Committee meeting on 05 November 2019

10.1 Karim Brohi (KB), Non-Executive Director, on behalf of Mark Spencer, Non-Executive Director and Chair of the Quality Assurance Committee, presented an update of the most recent meeting of that Committee to the Board, noting matters for escalation.

10.2 The Board observed the challenge regarding tracking of multi-dose bags from dispatch to administering the drug. The Committee was assured that this was receiving priority from the Chief operating Officer and the Chief Medical Officer

10.3 The Perfect Day was also acknowledged as discussed in the Chief Executive's report. Board members were informed of a correction to the information presented in the Assurance Report. Rather than resulting in a 40% reduction in conveyance across the capital, the day had seen reduced ambulance conveyance in NEL by approximately 9% between 8am-8pm, with the day ending at 51.6% conveyance compared to 64.1% on Monday 01 October 2019 and an average of 59.6% for a Monday in July.

(ii) Audit Committee meeting on 07 November 2019

10.4 John Jones (JJ), Chair of the Audit Committee, presented an update of the most recent meeting of that Committee to the Board, noting matters for escalation.

10.5 The Board noted the request to approve the Standing Orders and Standing Financial instructions as presented elsewhere on the Board agenda (minute reference TB/19/86) and that the Audit Committee recommended that the Trust Board (acting as corporate trustees) approve the London Ambulance Service NHS Charity Annual Report and Financial Statements for the year ending 31 March 2019.

10.6 Additionally the Board was informed that the Chief Medical Officer and Trust Pharmacist had presented to the Committee the outcome of the internal audit review of Medicines Management. The review had a rating of partial assurance and the recommendations had been agreed and would be progressed

(iii) Logistics and Infrastructure Committee meeting on 12 November 2019

10.7 Theo de Pencier (TdP), Chair of the Logistics and Infrastructure Committee, presented an update of the most recent meeting of that Committee to the Board, noting matters for escalation.

10.8 Consideration was given to the productive meeting which considered the backlog of works across the estate and the plan in place to track and deliver improvements. Further updates would be received and progress monitored at the January meeting of the Logistics and Infrastructure Committee.

(vi) People and Culture Committee meeting on 14 November 2019

10.9 Karim Brohi (KB), Non-Executive Director, on behalf of Jayne Mee, Non-Executive Director and Chair of the People and Culture Committee, presented an update of the most recent meeting of that Committee to the Board, noting matters for escalation.

10.10 Board members noted that strategic workforce planning was a key point of discussion and that a paper was planned for presentation to the Strategic Workforce Planning Group 20 November 2019. There had been substantial focus on this issue and the work needed to continue at pace.

10.11 A deep dive into sickness absence was carried out and it was noted that the Trust was well placed in comparison to other NHS ambulance trusts. The highest rates of sickness were noted to be in the Emergency Operations Centre (EOC)/111. The managing attendance policy is under review following feedback from staff side colleagues and chief executive roadshows.

(vii) Finance and Investment Committee meeting on 20 September 2019

10.12 Fergus Cass (FC), Chair of the Finance and Investment Committee, presented an update of the most recent meeting of that Committee to the Board, noting matters for escalation.

10.13 Board members noted that the Committee had reviewed the challenges associated with achieving planned service levels while also delivering the budgeted breakeven control total for the full year.

11. Integrated Quality and Performance Report (TB/19/79)

11.1 Lorraine Bewes (LB) presented the Integrated Quality and Performance Report, highlighting the key areas for note. The Board observed that the report brought together Quality, Operations, Workforce and Finance and it highlighted key risks and supported benchmarking of Trust wide performance against key national, local and contractual indicators.

11.2 The Board discussed "people"-related deliverables and the improved delivery of critical training, noting that it was necessary to maintain strong compliance. There were reduced conveyance rates to emergency departments and improvements continued. However, Non-Executive Directors expressed concern about the vacancy rate information provided within the report. It was confirmed that the information was not an accurate representation (that could be found within the Chief Executive's report, reference TB/19/75); the data had been skewed by those super-numeri staff who were in training and not part of the formal workforce. This would be amended in future reports.

11.3 The Trust's Health and Safety position had improved and the implementation of the health and safety review action plan had proven to improve performance. The Board was pleased that the team was now able to be more proactive than reactive. In particular, more was required in relation to musculoskeletal (MSK) injuries and associated sickness absence. Research and communications were being worked upon to ensure that the Trust was taking a proactive approach to review the incidents and preventing future injuries.

11.4 The Chair challenged the delays in the Trust's delivery of the flu vaccine to its staff. It was noted that the Trust was supply chain dependant; there had been initial delays, but a programme was now in place to improve and accelerate the delivery programme. The Board was also notified that staff were engaging with the process with high uptake where offered.

ACTION: FW/ALS to share the plan for flu vaccinations with the Board.

12. Board Assurance Framework and Corporate Risk Register (TB/19/80)

12.1 Philippa Harding (PH) provided an update on the Board Assurance Framework (BAF). Board members noted the top three risks which were Finance, Recruitment and Cyber security.

12.2 The Logistics and Infrastructure Committee had carried out additional work to understand the nature of its risks, following this a formal review of the potential risks that had been identified would be undertaken by the Executive, in order to articulate the challenges and develop remedial action plans. This information would be used to inform consideration of possible Board Assurance Framework level risks.

12.3 The Chair questioned the risk score levels in respect of staffing; it was agreed that progress had been positive but that the issue required further discussion and consideration. It was proposed that further consideration be given in particular to the possible risks associated with staffing in the EOC.

13. Serious Incident Update (TB/19/81)

13.1 Trisha Bain (TB) Chief Quality Officer, provided the Board with an update of the Serious Incidents (SIs) and thematic reviews. Board members noted that actions from closed investigations were complete or on track for completion within the provided timeframe.

13.2 There were 31 completed SI reports submitted to the Clinical Commissioning Group (CCG), with 19 of these being approved and closed upon review. These completed and submitted reports were from those SIs declared in Q4 (2018/19). There was also 1 de-escalation submitted and approved, and the remaining 7 cases were currently under investigation within their 60 day timeframe. The Trust's current position on meeting the 30 working day target for submission on SI reports remained at 100%.

13.3 As a result of the ongoing themes regarding delayed defibrillation, the Serious Incident Group carried out a thematic review into these delayed defibrillation incidents to examine common themes and identify any further actions required to support staff to ensure defibrillation is commenced in a timely manner. Information about this had been provided to the Quality Assurance Committee.

13.4 Patient Group Directions (PGDs) and incorrect doses of drugs being administered had also been identified as a theme. The Serious Incident Group carried out a review into PGDs to ensure that they were easier to follow. This review was carried out with the assistance of the central governance team and Trust Pharmacist.

13.5 The Chair sough reassurance that the information and learning from SIs was communicated across the organisation effectively; it was reported that there was a clear cascade and distribution of information through bulletins, podcasts, managers and round table feedback. Consideration would also be given to other methods of communication, such as screen savers. A report on how the new patient safety investigation framework was to be implemented in the Trust was due to be presented to the Board in January.

13.6 The Quality directorate continued to support the robust investigation of SIs, analysing and monitoring themes, which were discussed at the Serious Incident Assurance and Learning Group (SIALG). It was noted that SIALG was providing improved ownership within the operational teams, trend analysis and assurance that the organisational learning has been embedded which would improve the quality and safety of the care delivered to patients.

14. Workforce Race Equality Standard (WRES) Action Plan (TB/19/82)

Melissa Berry (MB), Diversity Consultant, joined the meeting to present this paper

14.1 Melissa Berry (MB), Diversity Consultant, presented the Workforce Race Equality Standard (WRES) action plan to the Board, which was asked to review and comment on the content. The report provided details of the WRES Action Plan for the LAS for the period of 2019/20 and was the second year of a three year plan.

14.2 Challenges associated with improving the positon and actions were discussed, noting the current diversity of the workforce and the improving position. The senior leadership team of staff at band 8c and above now included 19% BME staff, compared to 3 years ago where the percentage was 2%. In addition the Trust had achieved the 15% target BME staff ratio and was now working towards a 17.5% target.

14.3 The next phase of delivery would focus on enabling people to work comfortably with race equality issues; there would be a deep dive on the factors impacting black and minority ethnic (BAME) staff. Strengthening the network to support staff across the organisation and producing an associated strategy. Through communication and engagement and ensuring that the accountability of teams are embedded as teams are reorganised and updated to reflect new responsibilities. The value of role modelling was discussed. Reverse mentoring and sponsorship mentoring had been effective in addressing these issues and it was suggested that consideration be given to extending the trust's current sponsorship and mentoring programmes.

14.4 The Board chair thanked Melissa Berry for a comprehensive report, which provided clear assurance that the issues were being addressed.

15. Workforce Disability Equality Standard (WDES) Action Plan (TB/19/83)

Melissa Berry (MB), Diversity Consultant, was present for the consideration of this paper

15.1 Melissa Berry (MB), Diversity Consultant, presented the Workforce Disability Equality Standard (WDES) report to the Board which was asked to review and comment on the content.

15.2 Members were provided with a detailed summary of the report's content noting the ten metrics used to measure the experience of disabled and non-disabled staff across the organisation and that, although 3.4% of LAS staff declared a disability, this did not match with staff survey responses, where the figure was closer to 15%. This was a shared position across NHS Trusts nationally and work would be carried out across the organisation to validate the data available.

15.3 A task and finish group had been established to work on the identified action in the WDES action plan and regular updates were to be provided to the Equalities & Inclusion Group, the People and Culture Committee and the Trust Board.

15.4 It was anticipated that the positive outcomes of the plan would be more transparency and more accurate data reporting, increased declarations rates of disabled staff, improvement in staff survey indicators and the establishment of a staff disability and long term conditions group (the Enable network).

15.5 The Board Chair asked about less obvious conditions including neurolinguistics issues. There were a number of steps that could be implemented to identify and address these issues and clinical education support with this cohort of staff.

15.6 The Trust's timeliness in making reasonable adjustments was raised by Non-Executive directors, who noted that, in some cases this was having a detrimental effect on staff members and had resulted in concerns being raised through Freedom to Speak Up. The need to improve the process was acknowledged. It was suggested that consideration be given to specific service level agreements with the Trust's procurement team when these adjustments required the purchase of new equipment.

15.7 The Chair thanked Melissa Berry for her attendance and clear presentation.

16. Major Incidents in 2017 – Issues identified in inquests and enquiries (TB/19/84)

Paul Woodrow (PW), Director, joined the meeting to present this item

16.1 Paul Woodrow (PW), Director, provided a detailed presentation outlining the progress of inquests and enquiries associated with the major incidents that occurred in 2017.

16.2 The findings included in the report demonstrated that there were issues associated with cross agency communication and this was a key learning point that would require partnership working to resolve.

16.3 Further lessons learnt were discussed in detail, including the need to ensure there was sufficient resourcing to deliver the complex work that occurred following such incidents and to ensure that the health and wellbeing of staff affected was managed and protected appropriately.

16.4 The Board received detail of the actions taken to date and noted that the Trust's formal responses to the findings of the Grenfell Tower public inquiry and the London Bridge inquests were in the process of being developed. They would include action plans, which would be tracked through reporting to the Board, the Quality Assurance Committee and the Serious Incident Assurance and Learning Group

16.5 In respect of the terrorist attacks on London Bridge, Board members recognised that the LAS response was fast and effective and, as a result, lives were saved. The Board acknowledged that the media coverage could be a challenge for the staff involved in public inquests and inquiries and welcomed the fact that the Chief Coroner had recognised the bravery of LAS staff.

16.6 The Chair reminded members that PW was leaving the Trust and recognised the work that he had carried out, as well as his contribution to the LAS. The Board thanked PW and wished him well for the future.

17. Freedom to speak up quarterly report (TB/19/85)

Katy Crichton (KC), Freedom to speak up Guardian, joined the meeting to present this item

17.1 Katy Crichton (KC), Freedom to Speak Up (FTSU) Guardian, presented the report to the Board which provided detail of FTSU activities since July 2019 and the implementation of the LAS FTSU strategy.

17.2 In quarter 2 of 2019/20, 66 cases were raised and members noted that this was an increase when compared to the 118 raised during the whole 2018/19 financial year. The types of cases and the cohorts of the reporters were presented and discussed by the Board who acknowledged the variables that influenced the reports, including the full time availability of the Guardian, which was not common across NHS Trusts and demonstrated the importance of the role. However, it was acknowledged that further work was required to continue to raise awareness of FTSU and engage across the sectors and that this work is ongoing.

17.3 The Board acknowledged the willingness of staff to raise concerns and recognised that the responses to these issues were proportionate and timely. KC provided members details of the response process and the positive impact of the FTSU coordinator role that was now in place.

17.4 Attention was drawn to the successes of the FTSU culture across the organisation noting that a story had been published in the National guardian's office 100 voices Campaign, which aimed to highlight the experience of staff using the FTSU in different Trusts. Additionally the National Guardian's Office had recognised LAS as the most improved Trust for culture (with a 75% score in the FTSU index, the greatest overall increase in the NHS).

17.5 Finally the Board was asked to approve the Freedom to Speak Up policy as presented to support the delivery of works. The Board approved this request and the policy as presented.

RESOLVED:

17.6 The Board resolved to approve the proposed Freedom to Speak Up Policy (TP003).

18. Patient/staff Story (TB/19/89)

A member of the public joined the meeting to present this item.

18.1 A member of the public joined the Board to share his experience of the LAS, having made a complaint about the fact that his mother's end of life care plan had not been adhered to. He provided a candid explanation of the case detail, shared the impact that the decision making process had had on his mother and the family. They had not felt listened to and this had led to frustrations and stress that was unnecessary. The Chair thanked him for attending the Board and for his explanation, she confirmed that the complaint investigation had identified a number of shortcomings in his mother's care management and confirmed that all of the information had been available to assist the crew, there was sufficient evidence that hospital conveyance was not the correct decision in this case.

18.2 The staff involved in this case had been offered extensive feedback on the points that had been raised and the end of life care team had taken the findings and comments into account to help inform improvements to the care provided to palliative care patients.

18.3 The Chair apologised for his experience and assured him that the Board took these issues seriously and would ensure that the learning that had been identified would be implemented.

19. Standing Orders and Standing Financial Instructions (TB/19/86)

19.1 Lorraine Bewes (LB), Chief Finance Officer, and Philippa Harding (PH, Director of Corporate Governance, informed the Board that NHS Trusts were required to have Standing Orders (SOs) and Standing Financial Instructions (SFIs), and to ensure they are regularly reviewed to ensure they are up to date and robust.

19.2 The documents had been revised to reflect the new organisational structure, changes in tendering and reinforcing specific requirements in connection with consultancy spend. In addition the Audit committee have reviewed the document, discussed and approved the changes to the single tender waiver process.

RESOLVED:

19.3 The Board resolved to approve the amended Standing Orders and Standing Financial Instructions, subject to minor amendments to references to the Chair to ensure that the role was gender-neutral.

20. Report of the Trust Secretary (TB/19/87)

20.1 Philippa Harding (PH), Director of Corporate Governance presented the report of the Trust Secretary which provided the Board with details of Chairs actions, use of the Trust seal and proposed updates in respect of Trust Board policies

20.2 The Board was asked to approve the Policy for Development and Implementation of Procedural documents, the Conflict of Interest policy and the Learning from Deaths Policy noting that there were no material changes, other than an amended format. The Fit and Proper Person Policy had been amended significantly to include context and information about action to be taken should the Fit and Proper Person Requirement no longer be met.

RESOLVED:

20.3 The Board resolved to approve the following proposed policies:

- 20.3.1 Policy for the Development and Implementation of Procedural Documents (TP001);
- 20.3.2 Fit and Proper Person Policy (TP002)
- 20.3.3 Policy for Managing the Conflict of Interests (TP004)
- 20.3.4 Learning from Deaths Policy (TP005)

21. Trust Board Forward planner (TB/19/88)

21.1 Philippa Harding (PH), Director of Corporate Governance, presented the forward plan for Board meetings until the end of the 2019/20 financial year. The document was based on the business conducted by the Board in previous years and upon best practice in the construction of Board agendas

21.2 It was suggested that the Board should have visibility of both the Computer Aided Despatch (CAD) and Electronic Patient Care Record (ePCR) projects. The reporting of these projects would follow the correct governance and reporting routes.

22. Questions from members of the public (TB/19/90)

22.1 Two questions from the public had been received, which had been responded to under agenda item 8 (reference TB/19/17).

23. Any Other Business (TB/19/91)

23.1 There was one item of other business raised.

Dormant Limited Companies

23.2 It is necessary to revise the Directorship of the dormant London Ambulance Service NHS Trust Limited companies to replace Paul Woodrow (PW), Director, with Garrett Emmerson (GE), Chief Executive. Members supported this approach.

RESOLVED:

23.3 The Board resolved to approve that the Directorship of dormant London Ambulance Service NHS Trust Limited companies to be changed to Garrett Emmerson (GE), Chief Executive

24. Review of the meeting (TB/19/92)

24.1 Members reflected on the meeting, observing an engaging debate and efficient challenge together with a good quality of papers. The level of discussion was considered to be challenging and reflective or more comprehensive reporting.

24.2 Board members reflected on patient story, noting that this was a clear presentation which beneficial for the Board to receive. The story clearly linked to the Trust Strategy.

25. Meeting Close (TB/19/93)

The meeting closed at 14.45 pm. The next Trust Board meeting in public will take place on 28 January 2020, London Ambulance Service NHS Trust Headquarters, 220 Waterloo Road London SE1 8SD.

TRUST BOARD - Public Meeting: ACTION LOG

Ref.	Action	Owner	Date raised	Date due	STATUS On track 1 month late Over 1 month late CLOSED	Comments / updates *(i.e. why action is not resolved / completed)*
TB/19/29 para 7.4	Present an implementation plan to the Trust Board, identifying the infrastructure, funding and specialisms required to realise the Volunteering Strategy.	Antony Tiernan	30/07/2019	24/03/20	**On track**	Being developed with Director of Communications and Engagement. The plan is due to go to ExCo on 29/01/19
TB/19/30 para 8.4	Confirm to the Board the current cost of training for all staff Trust-wide, including the abstractions involved.	Tina Ivanov	30/07/2019	31/12/19	**1 month late**	Update requested
TB/19/51 para 7.7	Present a report on plans to deliver the national Cat 2 response time, taking into account the existing clinical, medical and operational resources.	Khadir Meer	24/09/2019	24/03/2020	**On track**	A piece of work is required to understand the modelling framework, the accuracies and inaccuracies and what needed to be delivered to resolve before the requested report can be presented.
TB/19/76 para 8.2	Develop a more structured terms of reference for the Board to consider for co-production with stakeholders at the informal Board session 17 December 2019.	Anthony Tiernan	26/11/2019	17/12/2019	**CLOSED**	This action has been completed - discussed at informal Board meeting in December 2019
TB/19/76 para 8.3	Engage with Karim Brohi (KB), Non-Executive-Director, on the feasibility of establishing a London Ambulance Service Youth Forum.	Anthony Tiernan	26/11/2019	24/03/2020	**On track**	
TB/19/77 para 9.2	Ensure that quality impact assessments of the plans in place to address the Trust's financial and staffing challenges are presented to the Quality Assurance Committee in January 2020.	Khadir Meer	26/11/2019	09/01/2019	**CLOSED**	This action has been completed - discussed at Quality Assurance Committee in January 2020
TB/19/77 para 9.3	Ensure that Board members receive regular updates on Trust performance during the winter period.	Khadir Meer	26/11/2019			Update requested
TB/19/79 para 11.4	Share the plan for flu vaccinations with the Board	Ali Layne-smith	26/11/2019			Update requested

London Ambulance Service NHS Trust

Report to:	**Trust Board**			
Date of meeting:	28 January 2020			
Report title:	Report from the Chair			
Agenda item:	06			
Report Author(s):	Heather Lawrence, Chair of the Trust			
Presented by:	Heather Lawrence, Chair of the Trust			
History:	N/A			
Status:	☐	**Assurance**	☐	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

The Chair's report provides an overview of meetings and events attended with external stakeholders of the Service since the last time the Board convened.

Recommendation(s):

The Board is asked to note this report.

Links to Board Assurance Framework (BAF) and key risks:

N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☒
Financial	☒
Workforce	☒
Governance and Well-led	☒
Reputation	☒
Other	☒
This report supports the achievement of the following Business Plan Work streams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

Report of the Chair

Farewells

1. At the end of December we thanked John Jones for his contribution as Non-Executive Director (NED) to the London Ambulance Service NHS Trust (LAS) over two terms of office. This will be the last Board meeting in public for Theo de Pencier, NED, who has also served two terms at LAS. Theo has been a reliable and supportive Deputy Chair to me, previous NED lead for Bullying and Harassment, NED lead for Health and Safety and Chair of the Logistics and Infrastructure Committee. Theo's experience in the logistics business has been well utilised at LAS and I am grateful to him.

2. Paul Woodrow left at the end of November after 29 years at LAS culminating in his role as Director of Operations. He had many leaving events to celebrate his service to LAS including the Board farewell dinner. A leaving tea was organised which included a video of comments from staff across the Trust giving him thanks, appreciation and much affection.

Recruitment of Replacement NEDs

3. The recruitment process for the two NED vacancies are well advanced. Saxton Bampfylde received 35+ applications for each position and we have shortlisted four high quality candidates for each position. I anticipate making recommendations to NHS appointments by Thursday 23 January 2020.

London Region STP/ICS Chairs

4. David Sloman, London Regional Director has announced the names of the senior health and care chairs appointed to lead London's five emerging Integrated Care Systems (ICSs) as follows:

North Central London	Mike Cooke
North East London	Marie Gabriel CBE
North West London	Dr Penny Dash
South East London	Richard Douglas CB
South West London	Millie Bannerjee CBE

Full details of the announcement can be found on the link below:

https://www.england.nhs.uk/london/2020/01/16/new-health-leaders-to-drive-health-and-care-in-london/

NHS Provider Board

5. At the beginning of January I attended my induction as a Trustee of NHS Providers. My role is to represent Ambulance Trusts and I have agreed to work in collaboration with Lena Samuels, Chair of Association of Ambulance Chief Executives (AACE).

6. The following day comprised of a full day NHS Providers Board meeting where I was able to emphasise the importance of changing the dialogue around accident and emergency performance and ambulances to one of Urgent and Emergency Care services. There currently is a piece of work aligning NHS Providers and ACCE on urgent and Emergency care culminating in the publishing of a report in the spring. The Trust has already contributed to this giving examples of where alternate pathways work for patients and hospitals alike. I am due to discuss this further with Adam Brimelow, Director of

Communications at NHS Providers on 21 January 2020 and our Director of Communications, Antony Tiernan, has a meeting with him at the end of the month.

AACE Chairs and Council meetings

7. In November I attended the AACE Chairs meeting and the AACE Council meeting. The Chairs meeting is now a useful networking meeting and a focus on urgent and emergency care. Presentations at the AACE meeting included an excellent best practice presentation around fatigue research and link to sickness (attached). The research evidence suggests that concentration deteriorates after ten hours of duty and calls into question the issue of 12 hour shifts. This is being investigated further in relation to LAS by our Chief Executive, Garrett Emmerson.

NHS Improvement/England (NHSI/E) Workforce Plan - Focus on culture

8. I attended a NHS Providers dinner with guest speaker Perena Issar, Chief People Officer, NHS Improvement who spoke about the NHSI/E Workforce plan and the focus on culture. She discussed with me her experience of spending time at LAS and how impressed she had been with how a call handler had dealt with a difficult call. She subsequently undertook a 'ride out' where she was similarly impressed by our staff, but shocked by the abuse from the public which she found to be racist and we discussed the crew response. I have since discussed with our Chief Operating Officer, Khadir Meer, on how we can better support staff. I am also following up on other aspects of her visit.

Visit to the SWL Sector

9. I visited St Helier Ambulance Station on 23 December 2019 and was delighted to spend time in the South West London sector with the recently appointed Assistant Director of Operations, Brian Jordan. We met with Ian Pullen, Locality Group Manager at St Helier, who understands his role very well and has an impressive approach to leadership. We discussed his approach with staff and the issues which he has encountered. Positive and professional relationships exist on station and with colleagues at St Helier hospital. The ambulance station was clean and orderly which emphasised the good quality inspection they had recently received, however issues did exist with responses from the estates function. Innovation was fully encouraged and Ian was in discussion with a non NHS facility to run yoga classes for the members of staff. I also met with Clinical Team Managers (CTMs) who felt under pressure with demands from other Trust departments despite also dealing with peak winter pressures and this had left them feeling overloaded. This is clearly an area for the Executive Leadership team to explore further.

10. At St Helier Hospital I spoke to a number of our crews. One issue that surfaced was the need to be more flexible in our rostering with an example given of a male paramedic who enjoyed his work but now at a more mature age found night duty difficult.

11. An example of the good relationship with St Helier hospital, was heard from the Deputy Chief Nurse who praised the Incident Response Officer (IRO). I also met an Accident and Emergency (A/E) consultant who was keen to discuss how best LAS crews could help with queuing in the A/E and was made aware of an acute clinician who was keen to discuss how LAS crews could take patients with certain presenting symptoms directly to the Acute Admissions Ward.

Heather Lawrence OBE
Chairman

safr
sleep and fatigue research

NHS
South Central Ambulance Service
NHS Foundation Trust

TRANSFORMING OUR OPERATIONAL MODEL & STAFF HEALTH & WELLBEING, WORK-LIFE BALANCE

OPERATIONAL SLEEP & FATIGUE STUDY

20 November 2019

Rob Ellery SCAS
Jason Eden Safr Ltd

Proud to be caring for you!

Contents

- SCAS Organisational Development Strategy
- Enablers for Change
- Safr Background
  - *Why Sleep and Fatigue Matters*
  - *Why a Fatigue System is Needed*
  - *The Safr System*
  - *Project Methodology*
  - *Results*
- Key Recommendations
- What You Can Do About Fatigue

Organisational Development Strategy

Employer of Choice

Improve our staff's

- Health & wellbeing
- Environment that supports work / life balance
- Retention
- Recruitment
- Communication
- Student support

Promote our staff's

- Health & safety
- Team working
- Improved work attendance
- Skills development
- Personal development

Provider / Partner of Choice

Continually improve services for our patients

- Transition to new ops model (ARP)
- Clinical enhancements
- Enable patients to get the right care they need first time, every time
- Enable improved performance
- Integrated health services

Enablers for Change

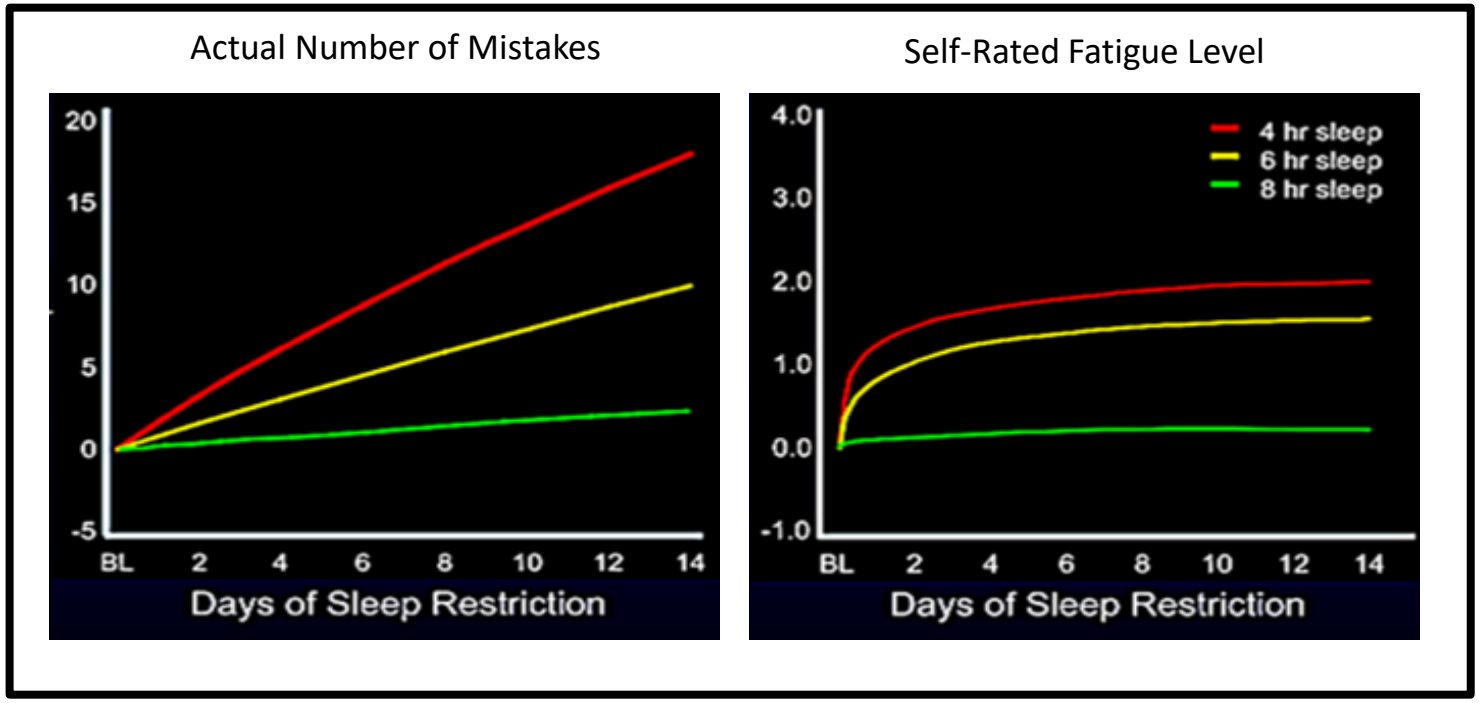
- Putting our staff at the heart of change
- Unique approach to transforming our operational service delivery model
- Listening / Communication & Engagement Events
- Provide improved H&WB, WLB – designing the best possible working patterns ands meeting service needs
- Commissioned an Independent Evidence Based Study to review the affects of Sleep & Fatigue (real-time)

Why Sleep and Fatigue Matters

- **Physical Health and Wellbeing:** Increased rates of cancer (50%), stroke (15%), diabetes, obesity and more
- **Mental Health and Wellbeing**: Anxiety, depression, PTSD, Alzheimer's, bi-polar disorder
- **Staff Safety**: road traffic accidents whilst commuting, H&S accidents at work
- **Patient Safety**:
  - More errors, clinical incidents, other incidents, and adverse events
  - Risk taking;
  - Decision-making and situational awareness

Why a Fatigue System is Needed

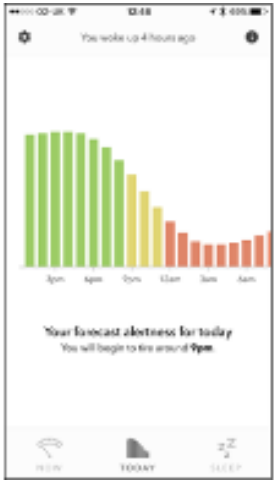
Human beings can't reliably judge how tired they are and for most people getting less than 8 hours sleep a night seriously impacts performance



The difference between how fatigued ***we feel*** (right graph)and how fatigued ***we actually are*** (left graph) is why we need a system to predict and manage fatigue

The Safr System

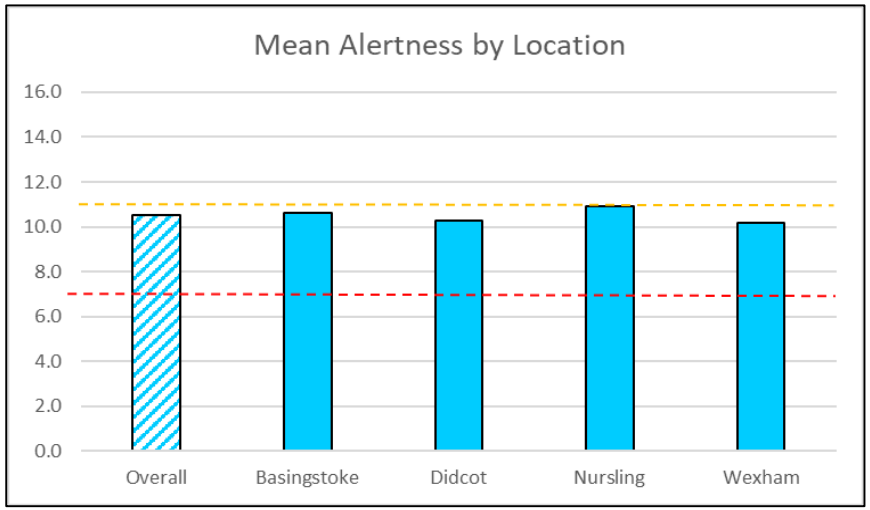
- Wearables to collect high quality data
- Mobile app to promote individual responsibility
- Team View software for tactical management
- Retrospective analysis for strategic decisions

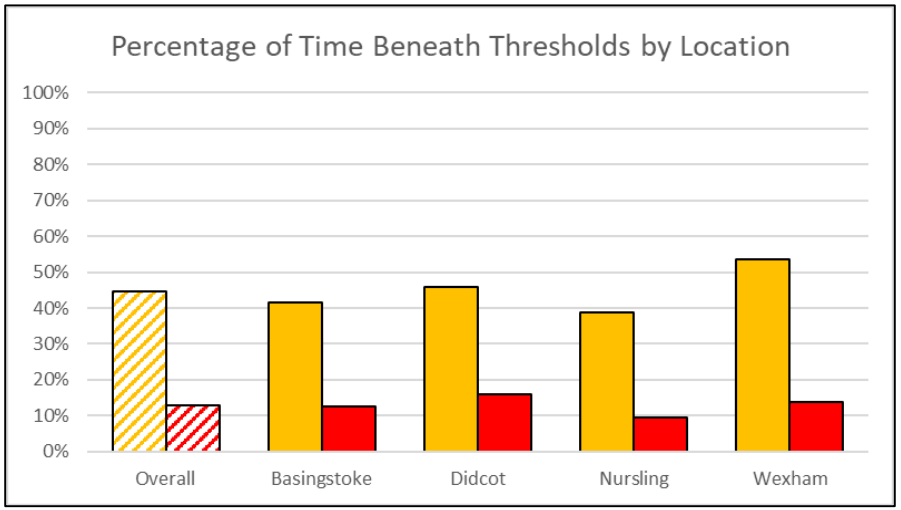


Project Methodology

- Collected sleep data using Fitbit Charge 2 and data about shift times from 90 Field Operations staff over a 3-4 week period
- Safr's bio-mathematical model of fatigue transformed that data into information about alertness levels
- Training, education, and supporting documentation about sleep and fatigue provided at project initiation
- Analysis of data was presented face-to-face and in a written report

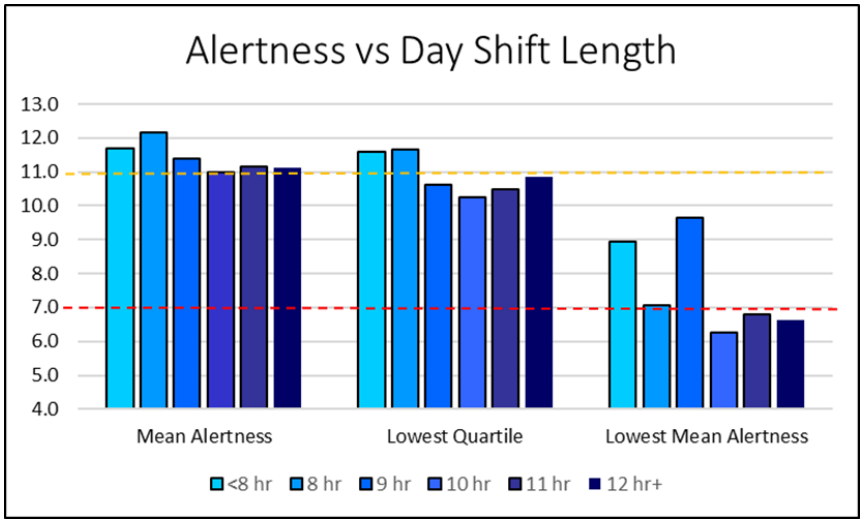
Results

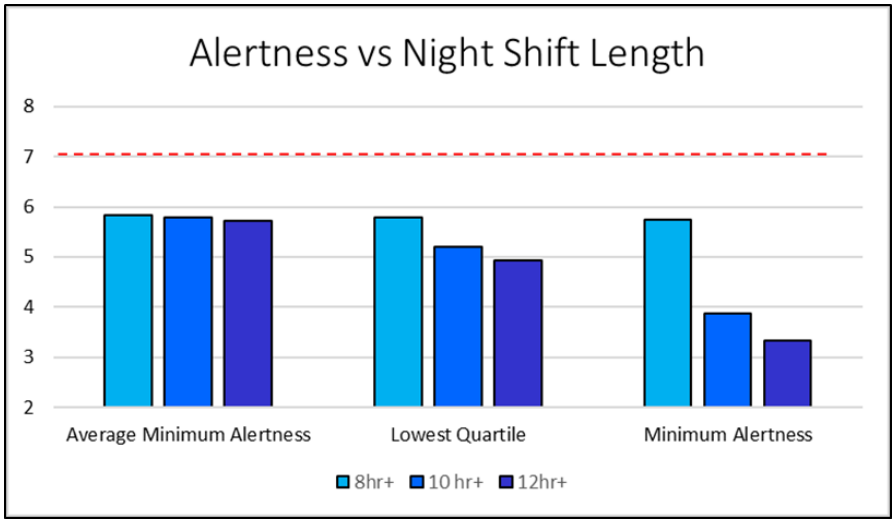




- Alertness reasonably consistent across locations. Mean alertness below ideal levels but in line with 24/7 organisations. Resource allocation appropriate?
- 45% of participants' time at work was spent beneath the amber threshold (double accident rate) and 13% below the red threshold (5 x accident rate).

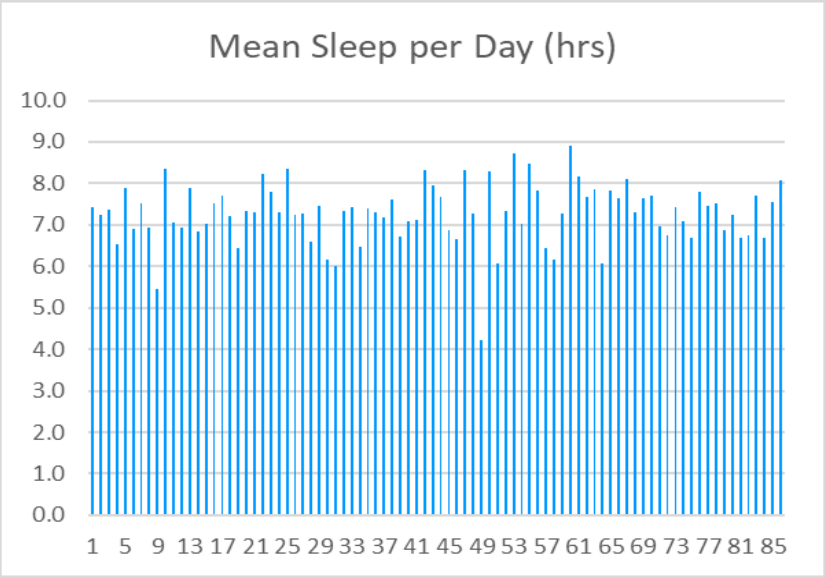
Results

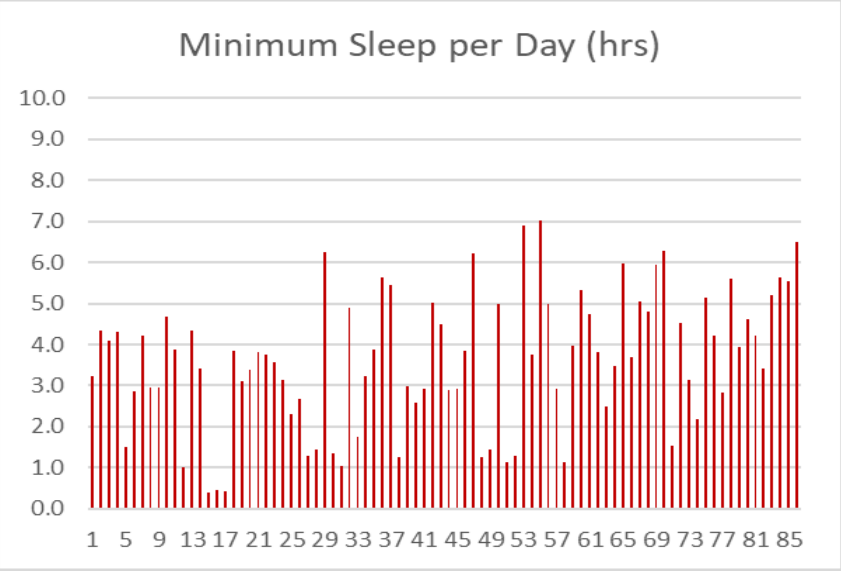




- Day shift alertness declines with length of shift to below the amber threshold.
- Alertness at night very low, especially lowest quartile and minimums.
- Action: Stop 12 hour night shifts.

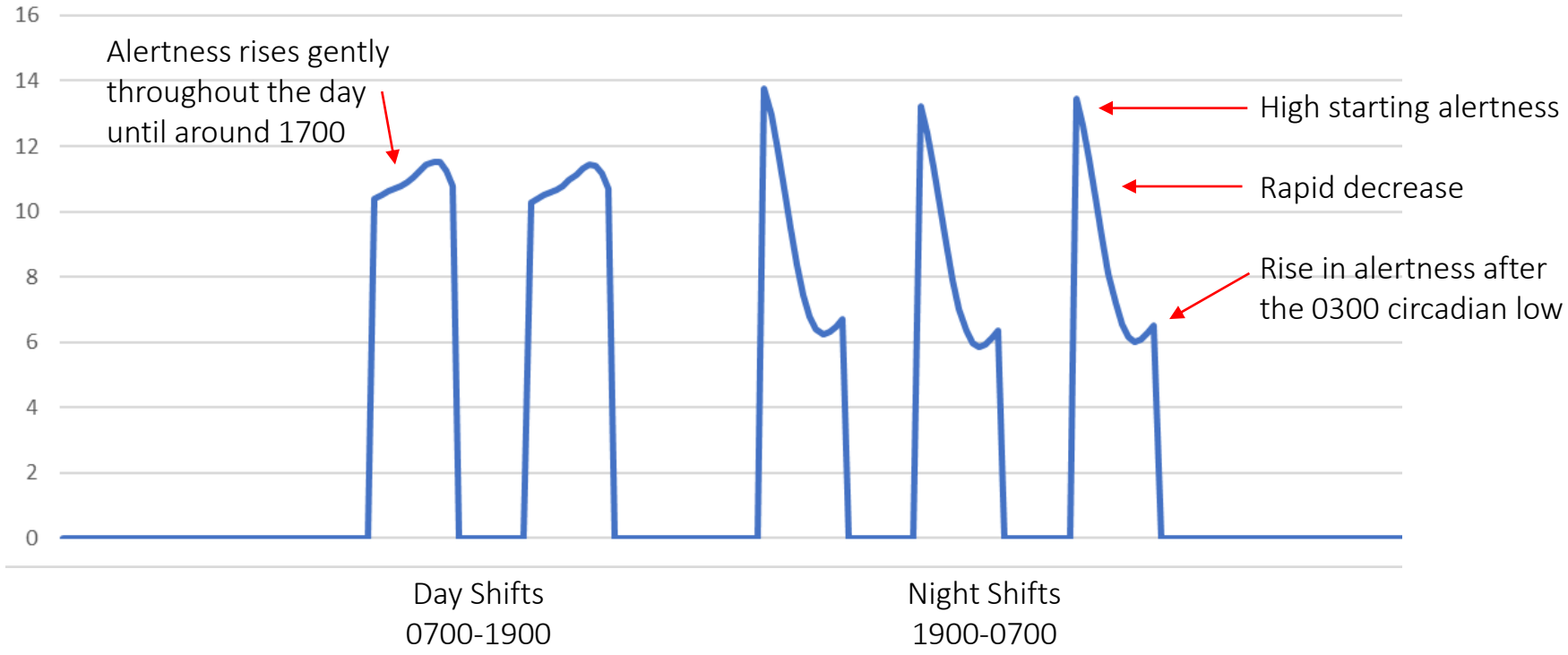
Results





- Mean sleep across the group was 7 hours and 18 minutes per night.
- 60% of participants recorded 4 hours or less sleep on at least one day during the project and 20% obtained less than 2 hours.
- Significant decrease in performance and an elevated likelihood of being involved in an event / incident.

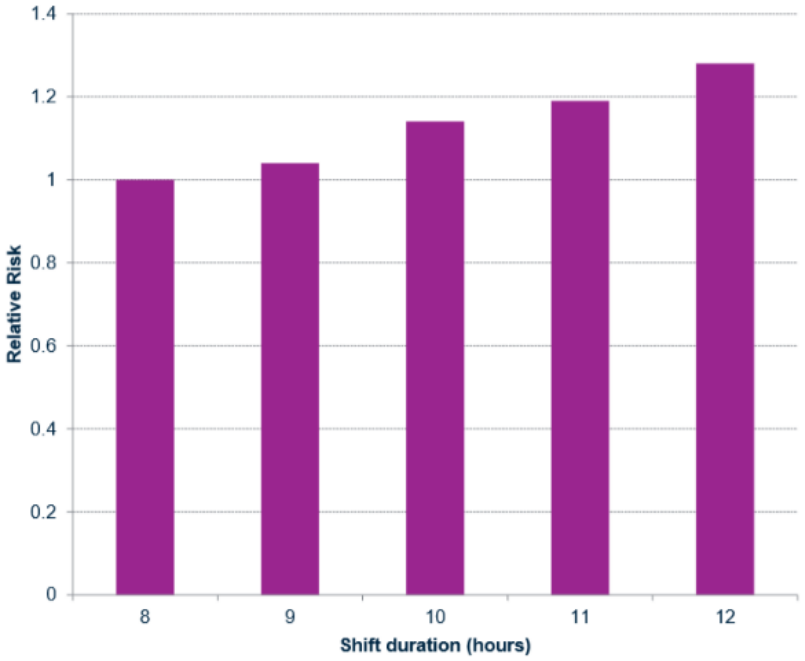
Day Shift vs Night Shift

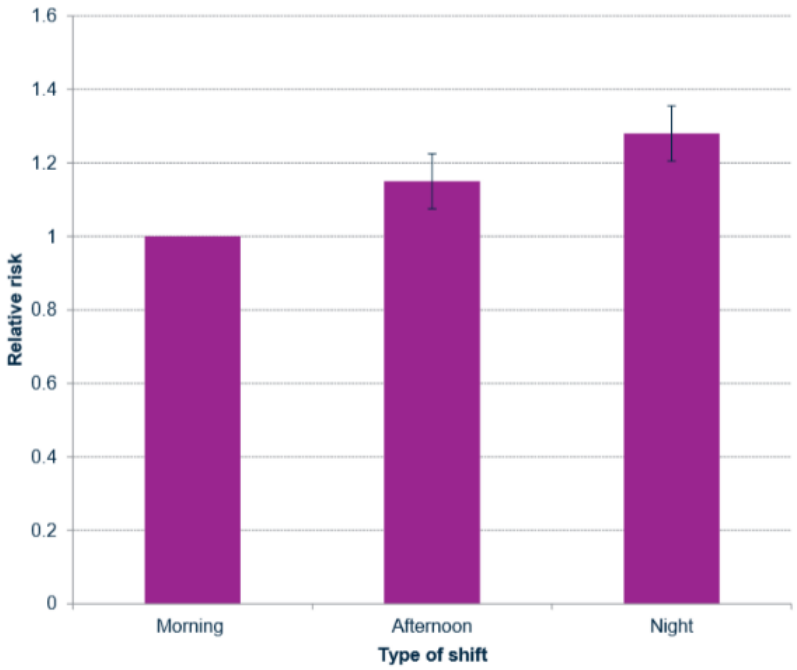


This shows the alertness at work of one SCAS paramedic. The 'zero' alertness parts of the line are when the person is not at work.

The day shifts have a much flatter alertness profile and higher mean alertness compared to the night shifts. Although the night shifts start with higher alertness (due to the combination of starting at a high point in the person's circadian rhythm and sleeping during the day) they fall away very rapidly leading to slightly lower mean alertness and much lower minimum alertness.

Research into 12 Hour Night Shifts





- 12 hour shifts in general (day and night together) have a 30% increase in the relative risk of being involved in an incident
- Night shifts also have an increased risk compared to day shifts
- 12 hour night shifts get both effects combined.
- Hence, 12 hour night shifts should be avoided.

(Redrawn from Spencer et al, 2006. Not SCAS data.)

Key Recommendations

- Shifts should last no longer than 12 hours. Reducing shift lengths over 10 hours should be considered.

- If it is not possible to reduce, both day and night shifts, focus should be on reducing the length of night shifts, particularly avoiding night shifts of 12 hours or more. Avoiding a high number of night shifts in a given period would also be beneficial.

- There is a need to develop new working patterns which take Recommendations 1 and 2 into consideration.

- A follow-on study should be conducted 6-12 months after any changes in shift pattern to assess the effectiveness of the changes.

What You Can Do About Fatigue

- Talk to your teams about fatigue
- Gather data
- Introduce a fatigue risk management system
- Feedback loop

- Contact Safr.org.uk;
  - Benchmark fatigue across Trusts
  - Rostering software with fatigue prediction and metrics

London Ambulance Service NHS Trust

Report to:	**Trust Board**			
Date of meeting:	28 January 2020			
Report Title:	Report from the Chief Executive			
Agenda item	07			
Report Author(s):	Garrett Emmerson, Chief Executive			
Presented by:	Garrett Emmerson, Chief Executive			
History:	N/A			
Status:	☐	**Assurance**	☐	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

The Chief Executive's report gives an overview of progress and key events within the London Ambulance Service NHS Trust (LAS) since the last time the Board convened.

The report is structured in sections, covering key areas of focus of the Trust and Board.

Recommendation(s):

The Board is asked to note this report.

Links to Board Assurance Framework (BAF) and key risks:

N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☒
Financial	☒
Workforce	☒
Governance and Well-led	☒
Reputation	☒
Other	☒

This paper supports the achievement of the following Business Plan Work streams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

Report from Chief Executive

1. This report provides the Trust Board with an update regarding key issues, events and activities since its last formal meeting.

Operational Performance

• Ambulance Services

	Cat1		Cat2		Cat 3	Cat 4
	Mean 07:00 mins	90th Centile 15:00 mins	Mean 18:00 mins	90th Centile 40:00 mins	90th Centile 2:00:00 hours	90th Centile 3:00:00 hours
Nov 18	00:06:16	00:10:29	00:18:47	00:38:14	02:06:05	02:51:50
Nov 19	00:06:44	00:11:13	00:22:19	00:46:29	02:57:44	03:48:51
Dec 18	00:06:18	00:10:31	00:20:53	00:43:53	02:30:02	02:54:14
Dec19	00:07:17	00:11:54	00:27:17	00:58:46	03:49:00	04:18:04

Figure 1: Ambulance Response Programme (ARP) key performance metrics

2. **Figure 1** above sets out our performance against our target response times for Category 1-4 incidents. We are, in the main, reaching our most critically ill patients within our target response times (we're slightly outside of the mean response time – by only one second - for category 1 patients in December 2019). Year to date for 2019/20 we are well within our Category 1 performance targets, with a mean performance of 06:36 minutes against a 07:00 minute target, and a 90th centile performance of 11:01 minutes against a 15 minute target. Year to date for Category 2 we are achieving a mean performance of 20:24 minutes, against a target of 18 minutes, and a 90th centile performance of 42:15 minutes, against a target of 40 minutes.

3. Our senior management team is focused on improving performance against the Category 2, 3 and 4 standards which, as can be seen from the above, are currently challenged, reflecting the significant increase in demand we are seeing across all services.

4. **Figure 2** below sets out this increase in demand in more detail. We received almost 15,000 more calls in November 2019 compared to November 2018 (an increase of 9%) and almost 18,000 more in December 2019 when compared to December 2018 (an increase of 10%); with the total number of incidents increasing by 4,300 (up 4.2%) in November 2019 and 3,027 (up 2.8%) in December 2019, compared to the same periods in 2018. On Friday 20 December 2019 ('Mad Friday'), we took 7,270 calls, the second highest figure since our records began in April 2000, and only the fifth time we've ever gone above 7,000 calls in a single day.

5. To meet the increasing demand, we are putting out more crews and ambulances than ever before. We increased our ambulance staffing by 19,307 hours (6%) in November and December 2019 compared to the same period the previous year, and our peak vehicle requirement (at the busiest times) has increased by 60 ambulances year on year for the same period.

6. Across November and December this year, we treated 7,327 more patients when compared to 2018. However, by treating more people over the telephone (hear and treat – an increase of 12% year on year) and on scene (see and treat – an increase of almost 14% year on year), the overall number of patients taken to Emergency

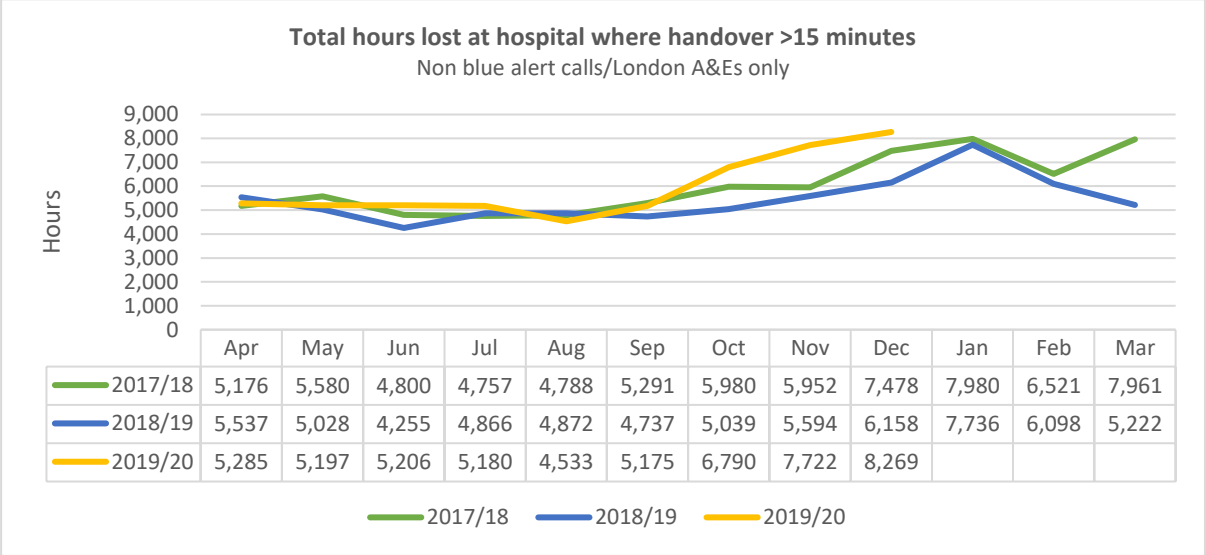
Departments during this period actually decreased by 1,406. This decrease has significantly supported the wider health system in London at a time where hospitals are reporting a significant increase in overall attendance (6.5%) and a reduction in performance against the national 4 hour benchmark (79.8% in December 2019 compared to 86.5% in December 2018).

Target	Demand						
	Total No of Calls received	Total No of Incidents	Hear and Treat	No of incidents attended	See & Treat on scene	Patients conveyed to non ED	Patients conveyed to ED
Nov 18	161,456	103,270	7,093 (6.9%)	96,177	25,227 (24.4%	8,976 (8.7%)	61,974 (60.0%)
Nov 19	176,423	107,570	7,694 (7.2%)	99,876	28,212 (26.2%)	8,758 (8.1%)	62,906 (58.5%)
Dec 18	172,917	108,821	7,878 (7.3%)	100,943	27,082 (24.9%)	9,139 (8.4%)	64,722 (59.5%)
Dec 19	190,629	111,848	9,091 (8.2%)	102,757	31,271 (27.9%)	9,102 (8.1%)	62,384 (55.8%)
Difference Nov-Dec 18 Nov-Dec19	32,679 +9.7%	7,327 +3.5%	1,814 +12.1%	5,513 +2.8%	7,174 +13.7%	-255 -1.4%	-1,406 -1.1%

Figure2: Demand for 999 services

7. Ahead of winter, we provided each London hospital with ambulance forecasting data for the winter period so that each hospital understands the number of ambulances they will be receiving each day, and by the hour, across the winter period and can factor this in to their winter planning.

8. In spite of the reduction in patients conveyed to EDs by ambulance, EDs continue to be under significant pressure from walk-ins and other patients demand. As a result we have seen hospital handover delays spike significantly since September 2019. **See Figure 3 below**.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	5,176	5,580	4,800	4,757	4,788	5,291	5,980	5,952	7,478	7,980	6,521	7,961
2018/19	5,537	5,028	4,255	4,866	4,872	4,737	5,039	5,594	6,158	7,736	6,098	5,222
2019/20	5,285	5,197	5,206	5,180	4,533	5,175	6,790	7,722	8,269			

Figure 3: Total Lost hours at Hospital where handovers are >15 mins

9. These delays at ED are impacting our ability to meet our category 2, 3 and 4 performance. We are currently losing an average of circa 300 hours a day of paramedic available time due to handover delays over the 15 minute standard. This equates to 15-20 ambulances being unavailable on any given shift. The delays are increasing our average job cycle times (JCT) by approximately 3 minutes, impacting our ability to get to all of our patients in a timely manner. We are working closely with

our Commissioners and Provider colleagues to manage this, and have deployed paramedics at the most challenged EDs in order to support cohorting of handover-delayed patients.

10. The Ambulance Services Directorate have been supporting the Tactical Operations Centre (TOC) this winter with a Location Group Manager working 1400 – 2200 daily to assist with reviewing, managing and reporting on Category 1 – 4 response times, 999 call handling performance, Integrated Urgent Care (IUC) performance, hospital handover delays, rest break allocation and out of service demands. There will also be a focus on increasing rest break utilisation to improve performance during shift handover times. TOC forms part of the Winter Plan 2019/20 to provide support and additional capacity to resolve issues which are challenging service delivery. We are also leading on daily winter conference calls. These are chaired by Trust Gold and attended by leaders from across the organisation with the aim to closely monitor and mitigate against increases in demand through a variety of different factors i.e. extreme weather, events, resource availability and pressures in the wider health system.

• Integrated Patient Care

11. The key performance metrics for our 111/IUC services are set out in **Figure 4** below. In line with the increased demand we have seen in 999 services, the number of calls being received by our IUC services is increasing. We received over 10,000 more calls to our IUC services in November 2019, compared to the previous month (an increase of almost 12%), and total demand for IUC services over November and December was 11% above forecast, with over 20,000 more calls received.

12. Call answering performance was challenged during November and December at both our South East London and North East London IUC services, as it was during November for other 111 providers. In addition, the number of calls abandoned by patients remains above target.

13. However, referrals to 999 services remain significantly below the 10% national standard for both NEL and SEL. This remains the lowest of all providers in London, indicating the benefits of a clinical assessment service (CAS).

Metric	November 2019			December 2019 (to 30/12/2019)		
	SEL	NEL	London	SEL	NEL	London
Total Calls Received Forecast	43,152 37,603	53,782 44,707	183,526	47,176 49,027	61,109 53,517	Not Available
% calls answered in 60s (Target 95%)	64.20%	53.24%	66.50%	76.00%	64.04%	Not Available
Abandonment Rate (target 5%)	6.21%	9.32%	6.53%	3.54%	6.09%	Not Available
% calls transferred to 999 (target 10%)	8.34%	8.64%	10.58%	7.75%	8.48%	Not Available

Figure 4: SEL & NEL Performance Metrics (including pan London 111 provider performance)

14. We are continuing to work to identify which patients benefit most from being managed via the Clinical Assessment Service (CAS) so that patients can have an advanced clinical assessment made and their care completed without onward referral. This significantly improves the quality of care provided over a standard 111 service and releases pressure on the wider healthcare system. The graph in **Figure 5** below shows that the development of our IUC services has enabled NEL and SEL to consistently outperform other providers in terms of A&E avoidance.

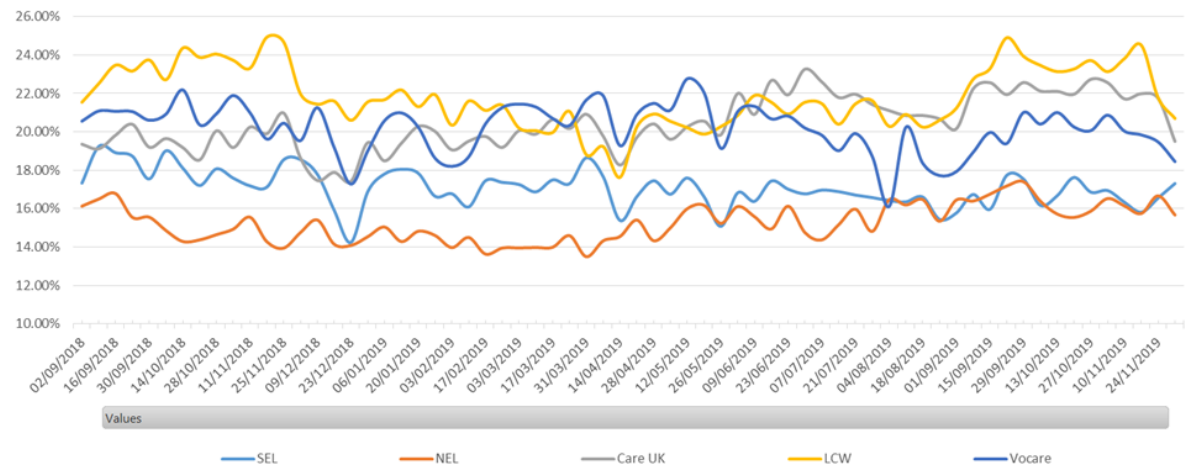


Figure 5: 111 calls recommended to A&E by London Providers

15. As reported in my last Board report, the Trust is working with system partners to commence a period of clinical hub transformation. Category 5 calls will be reviewed by the Clinical Hub, and those that are deemed suitable for clinical assessment by a 111 clinician will be electronically passed to the relevant service, via Adastra. From 14 January, Category 5 calls within the North East London (NEL) area, will be sent to NEL IUC/111. Over the coming weeks, this process will extend out further into the other areas of London in a phased approach. From 14 January 2020, the Trust began to implement changes to the way in which Category 5 calls are managed.

• IT & Technical Services

16. An interim Director of IT and Technical Services has been appointed from an internal candidate pool. The planned migration of the 999 telephony service to a newer platform resulted in a failed change over and required a roll back to existing infrastructure. No patient related incidents were identified during this process. An issue was identified with regards to the software version that was running on the platform. Steps are being taken to update the software and plan for future transition.

17. Planning has started for the move of the IT & Technical Services Directorate out of Union Street to Cody Road, Waterloo HQ and Pocock Street.

18. Due to server side problems a loss of service was experienced with the Data Warehouse. Reporting services were disrupted temporarily whilst we transitioned to the Bow servers.

• Strategic Assets & Property

19. The programme to repair station shutters and garage doors across the organisation continues. At the time of preparing this paper, 28 of the 32 required repairs have been completed.

20. The refurbishment works at the Trust's Waterloo headquarters continues. The final phase of the work is now underway, with the Medical Directorate moved to the newly refurbished offices on the second floor. The remainder of the first floor (east side) will create additional space to accommodate some of the teams located at Union Street so that we can vacate the site as planned in spring 2020.

21. The independent reviews of power management systems at Bow and Waterloo have been completed with remedial works required at both sites. A staging plan for

completion has been developed and project management resource is being identified. All key stakeholders have been engaged and contactors and associated costs are being gathered.

22. The Secure Drug Room (SDR) project continues, with building work continuing at Waterloo. A further 16 SDRs are to be completed. Final specifications have been reviewed and approved. Site surveys have been completed and drawings commissioned. All required contractors and stakeholders have been engaged with. The aim is to complete all SDRs by May 2020.

23. The Strategic Assets and Property team are undertaking a number of maintenance and testing workflows. Whilst some areas are considerably challenged, overall maintenance and testing compliance is at 77%. The estates team continue to work hard to clear backlog maintenance and improve the compliance position of the estate. Whilst a little behind the curve this position demonstrates a significant improvement (16%) in the last two months confirming forecast as to full compliance by year end as realistic.

• Fleet and Logistics

24. Fleet and Logistics team have successfully provided > 98% patient facing vehicle hours required by Operations. There has been a small increase in Out of Service for vehicles at the start of shift this is fundamentally due to increased demand to meet winter pressures. To mitigate this the fleet team have been working in conjunction with Operations and Scheduling to maximise availability. This has also seen extended workshop hours provided and increased use of contractors overnight to repair defects that would otherwise impact on vehicle provision the following day.

25. 21 of 112 new Double Crewed Ambulances (DCAs) have been put into service during December, increasing the DCA fleet to 456. The remaining 91 vehicles are to be shipped throughout Q4. These vehicles will then allow the supply of 400 vehicles into service every day to meet the operational requirement.

26. The first 4 vehicles being installed with driver safety and asset management system are in build, with the remaining 32 vehicles scheduled for completion throughout Q4. The technology incorporates CCTV on vehicles which will help to protect the security of our staff and support insurance claims; telematics will help us to better understand driving behaviour and improve our fuel efficiency; while equipment tracking in the back of the vehicle will support our processes such as make ready and allocation of vehicles to become slicker and faster. All Impact assessments have been completed and are in the process of being reviewed through the appropriate governance groups. The plan is to roll out these vehicles to frontline operations by the end of March 2020.

27. Bunkered fuel sites across the Trust have been cleaned and refuelled for resilience purposes. New fuel monitoring systems and hardware have been sourced allowing for remote management and monitoring of the stock. These will be supplemented by a further 7 bunkers installed at Make Ready locations enabling the Trust to review its use of personal issues fuel cards, exploit better market prices for bunkered fuel compared to high street prices (a saving of circa 6p per litre) and improve throughput via the Make Ready function in a bid to remove the need for clinical staff to undertake this role and incurring down time.

28. Following extensive review of other Trusts make ready services and a clear understanding of our requirement, a new specification of requirement has been developed. The tender for this service will commence in January 2020 with a view to go live in October this year. The tender shall include the preparation of FRU and NETS vehicles. The Make Ready service provides a quality assured vehicle preparation

process that maximises vehicle availability and reduces risk of infection control, allowing frontline staff to focus on their primary goal of caring for patients.

29. The Advanced Life Support (ALS) bags project has been completed with personal issue bags being collected and useable consumables being recycled. This project provides for a pre-packed vehicle based bag for each vehicle, equipped to a standard load list via our Make Ready teams.

30. The new vehicle based primary response bag has been rolled out to 4 sectors and roll out is due to complete by the end of January 2020. Like the ALS bag, this will see a standard bag provided for vehicles via Make Ready teams.

• Finance & Performance

31. As reported elsewhere on the agenda, the Trust year to date position at the end of November (month 8) was a £3.3m deficit, which was £1.3m worse than plan year to date, but represented an improvement in month and on the previous trend. Income at the end of month 8 was £8.3m higher than planned following agreement with Commissioners on the 2019/20 main contract and higher than planned income for apprenticeships, and training and education. Incident activity and call levels remain higher than planned. Expenditure was £9.5m higher than plan due to increased expenditure on clinical staff required to deliver safe clinical assessment in our IUC/111 services and to maintain performance with higher than planned activity growth. The Trust identified a number of significant risks to delivery of its control total earlier in the year and has mitigated a number of these through discussions with Commissioners. A number of risks remain and the Trust continues to focus on reducing cost through its financial recovery plan and is still projecting to deliver its agreed control total.

32. Our Forecasting and Planning team have been providing daily support to Winter Planning as well as testing forecasting accuracy across the whole winter period. They have developed the models required to support business planning for 20/21 and started to socialise these across relevant operational teams. The team has also been supporting the development of a planning tool for IUC using simulation software.

33. Our Business Intelligence team has been supporting work on Data Warehouse to ensure full resilience with our portal and daily reporting. The team also supported the sit-reps and evaluation required for the 999/111 integration winter pilot, and for wider mental health car roll out.

34. Our IUC Business Intelligence Analysts have been focussed on the development of a data warehouse for IUC data, which has improved our daily sit-rep reporting across IUC services. The team has ensured we can report on our daily staffing position as accurately as possible to support the financial forecasting for the remainder of the year. As well as leading the work to develop the IUC simulation model alongside the Finance and Planning Team.

• Clinical Directorate

35. To support operational teams managing winter pressures, all paramedics within the Medical Directorate have been undertaking a minimum of two patient facing shifts per month since November. This includes those in leadership positions as well as the Advance Paramedic Practitioners (APPs). The operational delivery of the service is further supported by the Senior Sector Clinical Leads, who have been supporting colleagues in operations to ensure they are up to date with current procedures and guidance. Feedback from frontline staff has largely been positive, who have appreciated the direct contact with senior clinical staff.

36. Together with colleagues in the Technology, Strategy and Development Directorate, the Clinical Directorate has started to scope out a model for the Trust being the employer of paramedics to work in primary care as part of the NHS Long term plan and new GP contract. From 2021, money will be available to Primary Care Networks to employ paramedics to support delivery of front line primary care. This exciting opportunity will allow a further expansion to the rotational paramedic model to include primary care placements. Significant work has also been undertaken to provide a pan-London network of clinical placements to support practice in GP surgeries and urgent care centres.

37. Over the last quarter, the Directorate has continued with a programme of team development sessions, which invited all members across different departments to contribute to the implementation of the Clinical Strategy. These sessions also brought a focus on the Trust values, and how as a Directorate these can be promoted. The latter part for the sessions saw the senior members of the Clinical and Quality Directorates come together, exploring ways it would be possible to enable a more cohesive and cross-directorate approach to work.

38. Within Clinical Education and Standards, interviews have been completed for the Education Management posts, and a new post to support 111/IUC/EOC/Chub has been recruited into. The Education Manager – Performance and Integration, is an interim role to support the transition of clinical education, helping to define the development and governance of the changes in structure and resultant performance outcomes. Further recruitment is to take place for Tutors and secondment opportunities.

39. The LAS Clinical Audit and Research Unit (CARU) has released the Annual Cardiac Arrest, ST-Elevation Myocardial Infarction (STEMI) and Stroke reports – these reports provide assurance about the level of care we provide to some of the most seriously ill patients we attend (these reports are provided to the Trust Board as additional reports for information elsewhere on the agenda for this meeting (ref: TB/19/119).

40. LAS has continued to provide excellent care to stroke patients in London, providing a prompt response, comprehensive assessment, and transporting patients to specialist centres. There was an increase of 4% in the number of patients presenting with a suspected stoke and 43% of these patients were identified at the point of the 999 call. 98.6 % of patients received the full diagnostic bundle and 99.7% of patients were conveyed to the most appropriate destination. The reduction in on-scene time, to an average of 31 minutes, and short journey times means that patients are getting to hospital quicker for prompt access to diagnostic tests and definitive treatment.

41. From 1 April 2019 to 31 March 2019, LAS clinicians attended 3,449 patients with suspected STEMI. Our clinicians continue to provide a good level of care to patients presenting with suspected STEMI and these patients received specialist treatment in hospital in a timely manner. The mean overall time from 999 call to arrival of an LAS clinician was 19 minutes, and on scene time was 39 minutes. 79% of patients received a conveying ambulance as the first vehicle to arrive on scene supporting the changes made in the Ambulance Response Programme of not delaying on scene waiting for a conveying vehicle. 78% of patients received the full STEMI care bundle and 99.7% of patients were conveyed to an appropriate hospital. Administration of analgesia to patients reporting severe pain remains a focus and the Senior Sector Clinical Leads are working in their areas to continue to improve this aspect of the care bundle.

42. Between 1 April 2018 and 31 March 2019, 10,152 patients suffered an out-of-hospital cardiac arrest and our clinicians attempted to resuscitate 4,004 (39.4%) of these patients. Resuscitation efforts were not undertaken for 6,148 (60.6%), with 4,386 of these patients being recognised as deceased on arrival of the clinician, and the remaining 1,762 had in place a Do Not Attempt Cardio-Pulmonary Resuscitation (DNA-

CPR) order, advanced directive or equivalent, or the patient's death was expected. Overall Return of Spontaneous Circulation (ROSC) to hospital increased by 3.2% to 35.7%. Overall survival to hospital discharge increased by 1.4% to 10.8%, up from 9.4% last year. Over three-quarters (76.1%) of patients received a Category 1 response with a mean response time of 7 minutes. The number of patients receiving bystander CPR decreased slightly by 1.2% to 64.1% but this still represents an increase on all years preceding 2017/18. A public access defibrillator (PAD) was deployed for 101 cardiac arrests, with one or more shocks being delivered by members of the public in 83 cases. Of these patients 79.5% had ROSC sustained to hospital (14.9% increase from last year) and for this group of patients survival to hospital discharge was 57.1% - an increase of 5.8% compared to last year (51.3%), clearly demonstrating the benefits of PADs.

43. CARU has published a paper in the British Medical Journal, demonstrating the strong appetite amongst paramedics to improve patient care through research. The department have also been shortlisted as finalists in the National Quality Improvement Network for their clinical audit work.

44. The fifth Advanced Paramedic Practitioner – Urgent Care (APP-UC) site will open at Ilford in January 2020, and will compromise of both experienced and new APP-UC working together. The new APP-UC cohort of staff are in the final stages of completing their induction and mentorship prior to going solo in both the control and operational environments. An expansion in the range of medicines available for the APP-UCs has been finalised for introduction in early 2020. Similarly new wound care equipment and associated training to enable completion of more episodes of care has been rolled out. The team is also excited about new equipment being introduced to assist in out of-hospital measurement of blood gas and chemistry that will support accurate diagnosis and provision of care outside of hospital. The device is expected to be during 2020.

45. A pilot to assess the feasibility of paramedic non-medical prescribing in the ambulance setting will commence with a small number of APP-UC staff in January 2020 and will continue throughout the year. The results of this will be used to guide and inform any future implementation of paramedic prescribing within the Trust.

46. Within APP-CC, a new procedure to allow the administration of thrombolysis (clot busting drug) in patients who have suffered cardiac arrest presumed to be due to a pulmonary embolism (blood clot in the lung) has been completed and training to support administration of this drug will commence early in 2020.

• Quality and Improvement

47. Following an inspection of the Trust's services and leadership in September 2019, on 3 January 2020, the CQC published its inspection report, rating the Trust as 'Good' overall, maintaining the overall positive rating published in May 2018 when the Trust came out of special measures. (This report is provided to the Trust Board elsewhere on the agenda for this meeting (ref: TB/19/107)).

48. The Quality Directorate is currently reviewing and refreshing the quality strategy and quality priorities for the 2020/21 Quality Account. The priorities will be based on themes identified in the recent CQC report as well as a gap analysis of ongoing trends from other internal sources. This strategy involves close working with the Clinical Directorate and alignment with the Trust business plans, with the aim of reducing variation and therefore providing outstanding care to our patients in every service.

49. Work has begun by the new Head of Quality Improvement and Learning to develop a quality improvement plan to take QI forward across the Trust. This will include further QSIR training of key staff groups to underpin the plan which will see sector QI hubs in

place. This will facilitate support, signposting and development of staff QI ideas into local, sector or Trust level improvement projects. The first 2 programmes relate to staff safety, Body Warn Cameras and MSK injuries.

50. The Trust has been confirmed as an early adopter in the NHS England/Improvement programme to implement the new national patient Safety incident Response framework (PSIRF), which will replace the current serious incident framework. There are only a handful of Trusts piloting this new framework ahead of it being adopted nationally. A second early adopters' day is being held in January and this will update the team on NHSE/I's approval process for the publication of PSIRF and begin the early adopter phase. The Trust has undertaken a gap analysis of what is required to implement the new framework and a stakeholder meeting will take place in due course. It is envisaged that the Commissioners will sign off the process in February in order for the Trust to start full implementation in March 2020.

51. On 1 November 2019, the Chief Coroner published his Prevention of Future Deaths (PFD) notice in respect of the inquests into the deaths of the victims of the London Bridge terror attack, which occurred on Saturday 3 June 2017. The Trust's response to the PFD was sent to the Coroner on 9 January 2020. (This report is provided to the Trust Board as an additional report for information elsewhere on the agenda for this meeting (ref: TB/19/120)).

52. The Trust's inquest support team is currently working with operational senior managers to gather information and learning from the London Bridge Attack in 2019. The data and information will form an action learning plan and will be used in preparation for the inquest, when called, which is expected to be in 2021.

53. The Trust maternity team is liaising with clinical partners across North East London's Local Maternity System to look at opportunities to extend alternative care pathways to women across all gestations.

54. A test of concept aligned to this work, is a project to understand the potential benefit of deployment of an advanced care paramedic specialist in urgent care to women at less than 20 weeks gestation. The aim of this project will be to provide an increase in the number of women having care provided in an early pregnancy unit in the first instance, and subsequently reducing both ambulance dispatch, and attendance at the emergency department.

55. The Trust maternity team has strengthened its capability to welcome a Practice Lead Paramedic to the team, whose role will complement the existing midwives. In December, the team completed their biannual "Maternatour" and utilised the "slido" mechanism to survey staff for their training needs. This feedback forms part of the annual training needs plan, ensuring the trust delivers a responsive programme of maternity education to both control room and road staff.

56. The Trust Macmillan End of Life care (EoLC) programme is being concluded and a business case to continue with the exceptional work of the team was presented to the Executive Committee at the end of February as part of the business planning process. There has been a 50% increase in the viewing of Coordinate My care (CMC) plans between November 2018 and November 2019. During the 'Perfect Day' the Macmillan End of Life Care team supported both 999 and 111/IUC by identifying EoL patients with a CMC plan and alerting crews to essential details. This was found to be valuable in influencing decision making and the potential for this role is being explored within the Clinical Hub.

57. The EoLC team also continue to work alongside Healthy London Partnership in relation to care homes and reducing unnecessary conveyances and instigating and promoting

the creation of new Alternative Care Pathways (ACPs) for facilitating the delivery of end of life care in the home setting. The EoLC Team is also working with Healthy London Partnership and a pan London multi agency forum (including police, coroners, nursing homes and GP/111) to address unnecessary emergency dispatches to expected deaths in the community. The final guidance document will be released early 2020.

58. The Trust Consultant Mental Health Nurse has been elected as chair of the national Ambulance Mental Health Leads Group.

59. Complaint response times remain on trajectory for the 2020 target of over 75%, with improvement noted in the recent CQC report. The main focus of 2020 is to further improve the quality of the responses. To this end, the team is inviting Peter Walsh, the Chief Executive of Action against Medical Accidents (AvMA) to work with the Patient Experience team on responses.

60. In addition, due to the main theme of complaints being attitude and behaviour of staff, a trend seen across all NHS organisations, we have asked if AvMA can support a research project to identify the key causal factors to enable LAS and other ambulance services to identify effective solutions. The work will be carried out from April 2020 onwards once the methodology has been agreed.

61. The Health and Safety team is further developing three Trust-wide improvement programmes of work in relation to:

- Body Warn Cameras: funding for a pilot has now been received and the Trust is exploring external experts in setting up the evaluation of the programme. In addition, individual staff from operations, Finance, People & Culture, Training and Education and Corporate areas have been identified to support the programme. A project board has been convened and the first meeting, chaired by the Chief Quality Officer, took place on 13 January. Progress will be reported regularly at relevant Committees.

- Musculo-skeletal (MSK): the Trust Health and Safety team is working in collaboration with the People and Culture teams to develop a comprehensive action plan aimed at improving the current high level of MSK injuries to staff. The plan is being developed into an improvement programme, using Quality Service Improvement and Redesign (QSIR) methodology and staff trained in improvement science to support this. This will also be reported via the relevant governance committees during the year against a clear improvement trajectory.

- Violence and aggression: incidents against staff have increased throughout the year and, in order to capture assault investigation outcomes, the Trust Health, Safety and Security Department has recently implemented a system to track and monitor reported incidents where staff have been assaulted and the police have arrested the assailant, or where police should have been requested because of the assault but were not called by staff.

62. To further improve communication between the Trust and the Metropolitan Police Service (MPS), a meeting was held in January with the MPS Lead for Operation Hampshire. A Memorandum of Understanding is being drawn up for agreement between the two organisations. This will enable an agreed joint approach and a robust response in dealing with assaults on LAS staff.

63. NHS England/Improvement is currently working on a project to gather data on staff assaults nationally, which is planned to go live from the 1 April 2020. The Chief Quality Officer and the Chief Medical Officer are currently contributing to this as part of the national Violence Reduction Programme.

• Strategy and Programme Development Directorate

64. The new Strategy and Programme Development Directorate has been established and the Sponsorship Team is being developed, with staff in post for Digital, Fleet and Estates.

65. The team is currently developing the Trust's three year business plan which will detail the activities that the organisation will deliver in the final three years of our organisational strategy. This has involved working alongside colleagues from Finance and Business Planning to support the business planning engagement process. Work is taking place within each directorate to identify the key activities for the next three years.

66. Whilst we were already planning for a pan-London roll out of the Mental Health Joint Response Cars (MHJRCs), following the success of 'Perfect Day', we agreed to operate this model of care across London from January to March 2020 as part of our winter resilience plan. The fleet is an expansion of our pioneering mental health car service which was launched in south-east London in November 2018 and will help alleviate the added pressure the Service experiences in winter months.

67. The pilot of this pioneer service paired an LAS Paramedic with an LAS Mental Health Nurse. This expansion will see us dispatching our Paramedics alongside a Mental Health Nurse from one of the ten Mental Health Trusts in London, who together will treat the physical and mental health needs of patients and only take them to hospital if appropriate. From Monday 13 January cars were operational from Waterloo, Greenwich and Wimbledon. From Monday 3 February, cars will be operational from Chase Farm, Ilford and Wembley. The cars will be operational every day between the hours of 11:00-23:00.

68. A significant amount of work has gone into designing the roll out both internally, and externally, including working with the Mental Health Trusts in order to put the appropriate governance structures in place and advertise for and select the clinicians to staff this service. The STPs and Mental Health Trusts have been very supportive of this piece of work. We will be conducting a full evaluation to identify the benefits or challenges associated with this model and the larger scale roll out. In addition, we continue to work with South London and Maudsley and Oxleas Mental Health Trusts to scope the continued roll out of this Mental Health service beyond the end of winter.

69. The Trust has successfully secured funding and a commercial partner to progress plans to deliver a Zero emission, low floor, sub 3.5t chassis, ambulance of the future. We aim to have a working demonstrator before April 2020 and should provide the basis for a cleaner more environmentally friendly ambulance, which reduces the risk of manual handling to staff.

70. We continue to work with Blue Light colleagues, to develop the London Emergency Coordination Centre (LESCC). This initiative was the product of a detailed piece of work undertaken across all three services (MPS, LFB and the LAS) under the Collaborative, Contact and Response (CCR) project. The purpose of this initiative includes (but is not limited to):

- Reducing unnecessary deployments
- Greater communication in real time between the three services
- Earlier escalation/de-escalation of incidents
- Shared situational awareness
- Collective view of risk resource and demand
- Pan London oversight

71. The three emergency services undertook a discovery table top exercise in November 2019 which was designed to seek assurances and test the high level assumptions of the formation of the LESCC. Initial results were positive and a further longer period of testing is scheduled to take place in February 2020.

• Communications and Engagement

72. Work continues on the establishment of a Staff and Volunteer Advisory Group with an inaugural meeting planned for late February or early March. The group, which will advise the Board on the way we support, communicate and engage with our staff and volunteers, will be jointly chaired by the Trust Chair and a member of the group. The membership will be as follows: staff survey ambassadors (circa 40); a representative from each of the Trust's staff networks – Lesbian, Gay, Bisexual and Transgender (LGBT+), Black and Minority Ethnic (BME) and Disability (ENABLE); and, volunteers (2). The group will meet approximately four times a year, with the first meeting focusing on our 2019 staff survey, which is due to be published in February.

73. Winter is traditionally our most challenging time of year with increased demand for services. Our communications activity is focussed on alleviating pressure driven by various factors from seasonal illnesses to excessive alcohol consumption.

74. Over the festive period, we achieved coverage of our messages across all major London broadcasters and print media including the Evening Standard, BBC London, ITV London, BBC London Radio and LBC. We received strong engagement with our advice on social media about a range of seasonal illnesses like flu and norovirus and messages signposting where to seek help when 999 was not appropriate.

75. For our alcohol campaign we supported the City of London Corporation's 'Eat, Pace, Plan 'campaign for the second year, offering 'ride-outs' to journalists and spokespeople ahead one of the busiest weekends for Christmas parties, securing coverage on ITV London and the Evening Standard. We put forward a 999 call handler to record alcohol messages for Transport for London to play throughout December over public address system at dozens of London Train and Tube stations. We exceeded our target for a 5 per cent reduction in alcohol-related incidents over these peak periods.

76. Our Gold Commander also undertook media interviews ahead of New Year's Eve to get sensible drinking messages out on BBC News and LBC, and we ran a comprehensive programme of social media activity which, based on videos of staff sharing key messages, attracted significant attention.

77. In early January, there was media interest in the findings of our Care Quality Commission inspection which once again rated our service as 'good' overall. It found evidence of 'outstanding' practice while noting some areas for improvement which we are already taking steps to address.

78. In November, a man was jailed for sexually assaulting a member of staff while they treated him. The emergency ambulance crew medic waived her right to anonymity to give an interview to ITV London to act as a deterrent. The story was covered by The Sun, Evening Standard and Daily Mail. This story was the most viewed on our website in 2019.

79. To show support for our Australian staff and emergency service colleagues in Australia, we set up a bushfires fundraising appeal in January. Inspired by a staff member, the campaign was popular both internally and externally, and has raised nearly £5,000 for the Australian Red Cross.

80. We launched our Community Education Volunteers (CEVs) training scheme in December 2019. The new CEVs are made up of frontline staff who receive specialist training to then deliver public education presentations to schools and community groups. CEVs give up their own time to deliver the presentations which range from issues such as knife crime and basic first aid.

81. Work continues on the development of our new Public and Patient Council, with a range of local and London-wide stakeholders invited to comment on the plans. The next step is to recruit members and two co-chairs, prior to launching the Council in April.

82. We have worked closely with SEL STP on their NHS Long Term Plan and contributed to their draft submission to NHS England and NHS Improvement which included a long term plan for emergency and ambulance services in the region. We anticipate the NHS Long Term Plans will be signed off soon.

83. STPs have also been focussing on their plans and transition towards a single clinical commissioning group which includes governance and the recruitment and appointment for a single Chair. The newly appointed chairs will be major stakeholders for us and we will undertake a concerted effort to forge strong relationships and foster partnership working to realise our strategy.

84. The above changes and the transition towards new structures resulted in a number of STP stakeholder forums being suspended during December. Nevertheless, we have engaged stakeholders across STPs, including working with colleagues at North East London STP on key areas such as the LAS pioneer services, and with operational colleagues, including by participating in STP A&E Delivery Boards, ensuring we played our role in responding to winter pressures.

• People & Culture

85. We closed December celebrating a 71.5% response rate to the annual staff survey, which is a 7% increase on last year (overall, 4215 staff completed the survey, which is 651 more than last year). The 2019 Staff Survey was launched on 23 September and ran until 30 November. The full set of results is not expected to be published until mid February.

86. The Trust continues to monitor Statutory Mandatory training compliance through the workforce dashboard, monthly reporting, weekly Core Skills Refresher (CSR) reporting and through performance review meetings. Completion of and compliance with Statutory Mandatory training requirements will form part of the new PDR appraisal policy which aligns to the 2018 NHS Pay Framework; this requires all managers to ensure their staff are compliant and all individuals to be compliant before they can progress through pay steps in the Framework. A communications plan is being devised which will roll out alongside the changes to CSR delivery to ensure all staff are clear of their responsibilities.

87. Compliance at the end of December 2019 was as follows:

- Trust compliance - 85%
- Operations -84%
- Corporate – 89%
- EOC (the subject of the CQC MustDo action) - 89%.

88. The Statutory and Mandatory Training Audit commenced on 5 November 2019 and continues, with Grant Thornton now working with various Subject Matter experts to address their audit specifics.

89. Almost all staff (99.82%) have logged in to MyESR. Over 4,000 e-learning modules were completed in December 2019, with 249,902 e-learning modules completed since MyESR went live.

90. The Trust started the 2019/20 year with an appraisal compliance rate of 76%. This has stabilised and improved to 78% but is below the 85% target. The improvement plan is being rolled out across Corporate and Operational teams with the support of People and Culture Business Partners and weekly reports are provided to Directors to facilitate the required improvement. This will be formally brought to the Executive Committee on a quarterly basis.

91. Work continues to refresh the interim PDR/Incremental Progression approach. The PDR Focus Group will be re-convened with an emphasis on ensuring we can address our Staff Survey action of improving PDR quality in addition to the quantity of appraisals completed.

92. Discussions have been held with the Director of Ambulance Services regarding the current limited stand down times available for frontline staff that may be impacting progress. Therefore, an Assistant Director of Operations will be part of the PDR Focus Group to ensure that messaging is consistent and clear going forward.

93. The Head of Leadership, Education and Performance (LEAP) is also part of the Operational Workplace Reviews (OWR) Working Group looking to transform operational performance management and appraisal processes

94. From February 2019 to 31 December 2019, we have achieved a compliance rate of 99% for Disclosure and Barring Service (DBS) checks, against our target of 100% (where staff have completed their ID checks and their on-line DBS application form). The People & Culture Managers are working with local managers to process the remaining 19 employees.

95. Our overall vacancy rate is below target at 2.7%.

96. In respect of Emergency Operations Centre (EOC) recruitment, the recruitment pipelines are now in place to address turnover. This month we have not seen the expected number of leavers and the vacancy rate has remained at 10% (down from the forecasted 13%). This has improved our end of year forecast from 5.5% to 4.3% (12.3 FTE vacancies). The plan for 2020/21 is to recruit to 110% of the establishment and additional training capacity has been planned to deliver this.

97. The paramedic and TEAC recruitment is on plan with a forecasted year end position of 48 FTE vacancies (1.5%). For those available to be rostered (the 'in-ops' rate), we are forecasting a 4% gap at year end (140 FTE). Currently, the 'in-ops' vacancy rate for our frontline registered and non-registered staff is 3.4% (114fte vacancies).

98. We have a plan to deliver to a 3,370 FTE Sector Operations frontline staffing establishment for 2020/21. The Sector Operations frontline recruitment requirements for 2020/21 are 536 FTE and the proposal includes both paramedic and non-registered recruitment to deliver this requirement. Our current recruitment plans are expected to deliver 410 FTE of the required 536 FTE for 2020/21. This leaves us with a current shortfall of 136 FTE. It is recommended that we proceed with the plans to recruit 400 paramedic staff and to reopen the Band 5 TEAC recruitment to address the current shortfall for 2020/21.

99. HR Managers have ensured that the newly implemented Selenity ER Tracker is fully utilised, following its implementation. Assurances have been put in place to verify the current Employee Relations activity is reflected on the system and the updated total number of open cases is 498.

100. To minimise the number future of Employment Tribunal cases, and to ensure current claims are addressed and closed in a timely manner, in house legal cover has been arranged. A service review is currently being carried out to ensure sufficient support and structure in place.

101. Following the action plans in place to take into account the recommendations included in the letter from the Chair of NHS Improvement, Baroness Dido Harding, and in line with the WRES strategy to create a 'Fair experience for all', a significant review of all core People & Culture policies is being undertaken to introduce new ways of working.

102. Following feedback from the autumn roadshows, a new Task and Finish group will be launched in January, inviting various stakeholders to appraise and comment on current Managing Attendance Policy (MAP) processes and propose changes. Two further Task and Finish groups will be convened to create a new annual leave policy and to improve the quality of PDRs and appraisals. Work on the Alcohol and Drugs policy continues.

103. Our Head of Recruitment, Averil Lynch, and Diversity and Inclusion Lead, Melissa Berry, presented to the College of Paramedics' quarterly meeting and discussed how they could support the Trust to increase the number of BME students studying paramedic science. As a result of this there is to be a follow up meeting with Greenwich University, St Georges and Anglia Ruskin.

104. The Trust hosted the National Ambulance Black and Ethnic Minority Forum and discussed a number of key activities, including the National Conference, a recruitment guide and 'Becoming a Culturally Intelligent and Inclusive Leader'. Our Chief Operating Officer attended.

105. On 3 December the Trust launched its new Disability Network,"ENABLE". The launch was timed to coincide with the global '#PurpleLightUp' campaign, designed to draw attention to the economic empowerment of disabled people. Across business and government alike, it has become synonymous with International Day of Persons with Disabilities (IDPD) held annually on 3 December. The Purple Day event was communicated on social media and provided an excellent opportunity for the Trust to demonstrate "Diversity in Action" as we celebrated Purple light Up.

106. Cohort 2 of the Reverse Mentoring Programme will be launching in February.

107. On Monday 13 January we held a Stress Management/Mental Health Workshop with Edmund Jacobs and Fatima Fernandez to begin design of the Management Essentials Stress Management and other training offering, which will roll out from Q1 2020/21. This workshop was requested by staff as part of the Staff Training Needs Survey in 2019/20.

108. Further dates of the Visible Leader have now been secured with our delivery partners and we have been promoting them on the RIB as well as writing out to those people who have yet booked on. Due to cancellation of operational places between December and February the final trajectory for The Visible Leader will take us to May 2020.

109. The work around the Occupational Health & Wellbeing scoping exercise has concluded and an executive summary and full report is now available. The next phase is to work with Procurement colleagues to develop the specifications across each of the lots, as well as presenting and seeking feedback from the People and Culture Committee.

110. Work on the organisational flu programme continues in earnest. To date, two thirds of staff have completed the on-line form and 50% have been vaccinated (17% have declined). All frontline areas have action plans in place to achieve an 80% compliance rate (forms completed) by 31January 2020. The 'Out of Hours' immunisation service is now underway and in its first month delivered over 200 vaccines. The team are also supporting the flu campaign in the course of their activity across the service.

111. Through the month of December, 30 Winter Wellbeing events took place, the primary purpose being the platform to deliver immunisations to our staff. These sessions were hosted at group stations and have served as a great opportunity to signpost staff to other services such as counselling/physiotherapy. These sessions will continue for the next 3-6months to bring all staff up to date on their vaccines and to issues immunisation passports to individuals. Through January 33 events will take place and will be promoted across all social channels to our staff to allow individuals to attend other complex events to suit their shift patterns and to encourage maximum attendance.

Garrett Emmerson
Chief Executive Officer

London Ambulance Service NHS Trust

Report to:	**Trust Board**			
Date of meeting:	28 January 2020			
Report title:	London Ambulance Service NHS Trust – 3 year business planning			
Agenda item:	08			
Report Author(s):	Adam Levy, Head of Strategic Development			
Presented by:	Ross Fullerton, Director of Strategy, Technology and Development			
History:	Trust Board Informal Strategy/Briefing/Development meeting on 17 December 2019 (ref: TBD/19/29) Logistics and Infrastructure Committee meeting on 14 January 2020 (ref: LIC/19/92)			
Status:	☐	**Assurance**	☒	**Discussion**
	☐	**Decision**	☐	**Information**

Background / Purpose:

The purpose of this paper is to update the Trust Board on the development of the 3 year business plan. This paper summarises a longer paper that was discussed in the Trust Board Informal Strategy/Briefing/Development meeting on 17 December 2019.

Recommendation(s):

The Board is requested to confirm that this paper reflects the direction the Trust is seeking to take in regard to business planning.

Links to Board Assurance Framework (BAF) and key risks:

N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☐
Performance	☒
Financial	☒
Workforce	☐
Governance and Well-led	☒
Reputation	☐
Other	☐
This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☐

Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

London Ambulance Service 3-year business planning

Our 2018 – 2023 strategy

1. In April 2018 Trust Board signed off our five year organisational strategy which outlined our vision of **building a world-class ambulance service for a world-class city**; London's primary integrator of access to urgent and emergency care on scene, on phone and online.

Our 2018 – 2023 strategic themes are:

Theme 1: Comprehensive urgent and emergency care coordination, access, triage and treatment, with multichannel access for patients

Theme 2: A world class urgent and emergency response with enhanced treatment at scene and for critically ill patients a faster conveyance to hospital

Theme 3: Collaborating with NHS, emergency services and London system partners to provide more consistent, efficient and equitable services to Londoners

2. The strategy also affirmed our organisational purpose which is to:

- Provide outstanding care for all of our **patients**
- Be a first class employer, valuing and developing the skills, diversity and quality of life of our **people**
- Provide the best possible value for the tax paying **public**, who pay for what we do
- **Partner** with the wider NHS and public sector to optimise healthcare and emergency services provision across London;

Our 3-year business plan

3. Historically, the London Ambulance Service NHS Trust (NHS) has produced yearly business plans which has limited our ability to effectively plan for the long term. As we enter the third year of our five year strategy, this plan will set out the delivery of the final three years of the strategy to 2023. The key rationale behind this longer business planning horizon are:

    - Department of Health and NHS England planning guidance
    - Our contract with commissioners is likely to be for three years
    - Integration across 999 and 111 will be delivered across the three years
    - We need to tackle the systemic challenges in the trust that are harder to tackle in a 12 month planning cycle.

4. Whilst this business plan is focussed on delivering the final three years of our strategy, we have identified ten key commitments which we will seek to deliver against through this business plan over the next three years.

1. Established Lead Provider and integrator of access to emergency & urgent care in London	6. A technology enabled service
2. Consistently outstanding operational performance	7. Transforming operational estate
3. Clinically & quality transformed patient care	8. A cleaner more environmentally aware business
4. Transforming our culture and supporting our people	9. Volunteering transformation
5. Organisation transformation	10. A financially sustainable organisation

Details of how we will seek to deliver these ten commitments is contained in appendix A.

Integrating 999 and 111/IUC services in London

5. Currently the 999 and 111/IUC (Integrated Urgent Care) services in London are delivered through at least six separate contracts. The London Ambulance Service operates the pan-London 999 service as well as the 111/IUC services in North East and South East London following successful bids for those contracts. However, as detailed in our 2018 – 2023 strategy, we believe that there would be benefits to patients and the wider NHS system to have an integrated 111 and 999 system for London overall.

Our ambition is to deliver an integrated system of access to NHS Urgent & Emergency Care services

This integrated service would:	**The key benefits of this integration would be:**
• Fully integrate 999 and 111 call management and provide seamless access to clinical assessment, triage and onward referral • Provide patients with the right care, first time and parity of NHS service provision regardless of how they first access that care • Empower frontline clinicians to offer patients the most appropriate referral options to continue management of their care through integration with London U&EC, primary care, mental health and community-based services	• The delivery of exceptional quality of clinical care irrespective of where the patient is calling from • Reducing inappropriate delays and unnecessary demand flow on the most pressured parts of the system • Reducing whole scale London NHS system costs • Improving the resilience of the U&EC system and maximising the benefits of interoperability

6. An integrated 999 & 111 service would help to achieve equitable service provision with comparable service models across the region. In recognition of the current complexities of all 5 STP contractual models, future commissioning arrangements would need to simplify and standardise our service provision in order to:

   - Achieve greater economies of scale
   - Reduce transactional complexity across provider and commissioning organisations Create workforce efficiencies through integration resulting in the avoidance of unnecessary duplication
   - Improve patient experience of Urgent & Emergency Care services

7. As the existing pan-London provider of 999 services and an established 111/IUC provider we are uniquely placed to be able to deliver this integrated service across the capital.

Contract and commissioning approach

8. In order to achieve integration between the 999 and 111/IUC services, we need a new approach to how we are commissioned and how IUC services are commissioned more broadly across London. Key elements of this approach could be:

   - A contract form for an integrated alliance model based on either lead or prime provider model; one overall contract with multiple service specifications on behalf of STPs for 999/111 call management and 999 ambulance response
   - A single CAS provider within the alliance model, with operational management of CASs remaining with STPs
   - Consideration of how this single contract would be managed and hosted with appropriate oversight

9. This proposed approach will be dependent on the ambitions and priorities of commissioners, STPs and the wider regional NHS system.

Timeline for business plan development

10. The table below details the key review and governance stages as part of the business plan development process

Date	Review Stage
6 February	Executive Committee review of draft business plan
21 February	NHSI draft operating plan submission
26 February	Executive Committee review
2 March	People & Culture Committee
3 March	Quality & Assurance Committee
10 March	Logistics & Infrastructure Committee
17 March	Finance & Investment Committee
18 March	Final Executive Committee Review
31 March	Trust Board

Ross Fullerton
Director of Strategy, Technology and Development

Appendix A - Our 10 ambitions and some of the ways in which we will achieve them

1. Established Lead Provider and integrator of access to emergency & urgent care in London • Single integrated 999 & 111/IUC contract for London • 3 year contract to achieve the vision of integrated care • Leading partnership delivery, with clear and affordable contract specification, and clear timelines for delivery • Integrated London-wide contract governance and oversight framework	**6. A technology enabled service** • A fully digitised clinical workflow to provide real-time access to patient data • Universal clinician use of patient records to improve care • New MDT solution & driver safety systems in vehicles –reduced accident rates and safer driving • Integrated triage across all channels with improved and support call handling and quality with automated AI tools
2. Consistently outstanding operational performance • Top quartile for all Ambulance Quality Indicators (AQIs) • Recruited sufficient paramedics for deployment to Primary Care Networks by April 2021, and meeting operational demand • 30%+ consult & complete by telephone • The outcome of a Strategic Workforce Review may impact on the current service model and workforce skill-mix.	**7. Transforming operational estate** • Consolidation of ambulance stations, workshops and Vehicle prep • Fully commercial approach to estates development, aiming for lower levels of operating costs. • At least one Ambulance Deployment Centre operational • Training consolidation into 2/3 digitally enabled learning environments • Control Centre and Call Centre integration
3. Clinically & quality transformed patient care • c50% conveyance rate to ED and improved ACP use • Improve cardiac arrest survival rates • Improved trauma outcomes by reducing on-scene time • Reduction in patient complaint rates / improvement in patient plaudit rates	**8. A cleaner more environmentally aware business** • Emissions reduction targets (air quality and climate change) • Improved energy ratings for our estate • At least 25 zero emission ambulances in operational use • Waste and plastic reduction
4. Transforming our culture and supporting our people • Management and 'Peer to Peer' bullying • Achieving WRES indicators • Sector leading sickness absence (sub 4% overall) • Zero tolerance approach to physical injury at work & reducing muscular-skeletal injuries by 10% year on year to reach zero • 25% reduction in physical and verbal assaults on staff	**9. Volunteering transformation** • 100,000 well engaged and productive volunteers, cadets and responders • Doubling Emergency Responder and CFR numbers • 1000 non-clinical volunteers • LAS Cadet programme, linked to the new St John's run NHS Cadet scheme • 10,000 public access defibrillators
5. Organisation transformation • Successfully integrating the way we identify, prioritise, develop, deliver and implement projects right across the business • Bringing together Strategy and project development (Sponsorship), separate from project delivery and end users • Developing a clearly prioritised and adequately funded capital programme to support strategy delivery • Funding to support delivery of the 2019/20 projects currently in progress	**10. A financially sustainable organisation** • A Radical Programme of CIPs to deliver a 30% reduction in corporate cost • Maximising the value and efficiency we extract from our supplier base • Significantly increased funding from other sources (e.g. sponsorship, advertising, licensing, property) and maximising use of our assets • Attracting much more capital and other grant income from government and other sources • More extensive use of Charitable donations to compliment parts of what we do

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	28 January 2020			
Report title:	National Procurement of Double Crewed Ambulances			
Agenda item:	09			
Report Author(s):	Chris Rutherford, Fleet Sponsor			
Presented by:	Ross Fullerton, Director of Strategy, Technology & Development			
History:	Presented to Executive Committee on 15 January 2020			
Status:	☐	**Assurance**	☐	**Discussion**
	☒	**Decision**	☐	**Information**

Background / Purpose:

The purpose of this report is to provide the background and relevant information for the Trust Board to approve a procurement strategy for double crewed ambulances (DCAs) in line with the Trusts ambition for a lightweight, zero emission capable, fully accessible vehicle. This will allow the Trust to complete the commitment papers required around the national procurement.

We have four core objectives for our future fleet:

- Low Floor access to reduce frequency of musculoskeletal (MSK) injury to staff
- Light-weight vehicle to remove requirement for class B2 driving licence
- Zero emissions capable
- Low total operating / lifetime vehicle cost

The Trust needs to replace at least 158 double crewed ambulances (DCAs) across the next 3 years in order to be compliant with the London Ultra Low Emissions Zone (ULEZ).

NHS Improvement (NHSI) is leading a national procurement of DCAs in line with the recommendations in Lord Carter's report into ambulance productivity. The NHSI programme requires a commitment to purchasing volumes to inform the next phase of their procurement. It is unclear from the current procurement specification that the successful bidder would deliver a vehicle that has appropriate dealer support in the London region. The proposed national specification fails to meet three of our four core objectives.

London Ambulance Service NHS Trust (LAS) is the lead trust for future vehicle specification and innovation projects under the national procurement programme.

Recommendation(s):

The Trust Board is asked to agree that the Trust should:

1. Make no commitment to purchasing new DCAs via the national procurement in FY20/21 and 21/22.

2. Develop and deliver 30 innovative new DCAs in each of FY20/21 and 21/22 that are lightweight, low floor and provide value for money.

3. Separately, complete the Project Zerro prototype of a low floor, lightweight, zero tailpipe emission DCA funded by InnovateUK.

4. Procure the remaining DCA volume as low / zero emission capable in FY22/23.

This approach will require approval by NHS Improvement (NHSI) however indications at the national fleet group suggest this is agreeable.

Links to Board Assurance Framework (BAF) and key risks:
N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☐
Performance	☐
Financial	☐
Workforce	☐
Governance and Well-led	☐
Reputation	☐
Other	☐
This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

Summary

1. NHS Improvement (NHSI) has been working on a national specification of ambulance following the Carter review that will form part of the core contract with London Ambulance Service NHS Trust (LAS) to ensure all new Double Crewed Ambulances (DCAs) are purchased via a national route. The Trust need to commit their minimum requirement for vehicles in January which will form part of the procurement process using aggregated volumes from each Trust. Whilst LAS agreed with the principle of the national specification, it identified that the minimum weight requirement was opposed to LAS ambitions for a lightweight vehicle allowing for B class licence holders to drive the vehicles.

2. The specification did not allow for progression towards an ultra-low emission vehicle and whilst it would have complied with the Ultra-Low emission zone (ULEZ), would not comply with the Mayor of London's ambition for a zero emission zone starting in 2025. Most Trusts have open consultations around clean air zones (CAZ) but only London's has started in April 2019. If a similar timescale to ULEZ is set for zero emission zones, the whole of London would be required to have zero emission capability by 2029.

3. LAS needs provision for a minimum of 400 DCAs per shift. The current DCA fleet is 450 vehicles. LAS are commissioning 112 new DCAs so the fleet size will swell to 562 however there isn't the communications equipment or medical devices in the service to support that number of vehicles at present. With an estimated 100 vehicles off the road per day for planned maintenance, unplanned maintenance, road traffic accidents and faults with radios, medical equipment etc, this would leave 462 available vehicles so it is recommended to decommission approximately 50 vehicles that are not ULEZ compliant and are ageing. This would leave a total DCA fleet of 512 which is over the growth target previously set.

4. There are currently 242 ULEZ compliant DCAs in service plus 112 new vehicles currently being commissioned which takes the compliant vehicles to 354. If the fleet is grown to 512 in 2020 with the respective communications and medical equipment purchased, this would leave 158 vehicles to replace with a minimum of Euro 6 engine standards by October 2023 when the Trust's memorandum of understanding (MOU) with Transport for London (TfL) expires around the ULEZ zone and the ULEZ zone is expanded to cover the whole of London.

5. It had been planned to replace 70 DCAs per annum with three years of replacements required to become compliant with ULEZ and then start to maintain a reduced age profile for the fleet. Replacing 70 box body or commercial vehicles per annum would maintain the fleet average age and be within the scope of the vehicles design life (7 years). By switching to a van conversion DCA, the vehicles would need to be replaced more frequently at 5 year intervals therefore requiring 100 DCA's per annum.

6. Modelling shown is for ULEZ compliance:

Age compliance model with varied funding

Year	Vehicle	In service	ULEZ		Number of vehicles still required at their replacement date											Vehicles due to be replaced	Fleet growth	
			Compliant	Non-compliant														
					2013	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025			
2018	DCA's	449	242	207	1	66	58	18	64	0	0	103	0	57	82		-	
2019	DCA's	474	354	120	0	0	38	18	64	0	0	103	0	57	82	112	25	
2020	DCA's	500	424	76	0	0	0	12	64	0	0	103	0	57	82	70	26	£10,500,000
2021	DCA's	500	494	6	0	0	0	0	6	0	0	103	0	57	82	70	-	£10,500,000
2022	DCA's	500	564	-64	0	0	0	0	0	0	0	39	0	57	82	70	-	£10,500,000
2023	DCA's	500			0	0	0	0	0	0	0	0	0	57	82	39	-	£5,850,000
2024	DCA's	500			0	0	0	0	0	0	0	0	0	0	82	57	-	£8,550,000
2025	DCA's	500			0	0	0	0	0	0	0	0	0	0	0	82	-	£12,300,000
																500		**£58,200,000**

Year	Ambulance % c	Ambulance number compliant
2018	53.90	242
2019	74.47	354
2020	84.80	424
2021	98.80	494
2022	100.00	500

Options

7. LAS is not content that either the current box body conversion or the proposed national specification are the best design of ambulance to fulfil future requirements for a lightweight, zero emission capable, accessible vehicle. LAS have started a Project called Zerro to develop a new type of ambulance that is based on a super low floor chassis for improved accessibility, is lightweight and will be zero emission. This is currently in development and will not be ready for at scale purchasing for 2 years. Procurement options for this would start in 22/23. As such, there are several current options available to LAS for the next three years:

   7.1 Replace 50-70 vehicles per annum for 2 years (plus one potentially) from the national specification and then purchase the super low floor vehicle.

   7.2 Replace 50-70 vehicles per annum with a derogation to the national specification on a base vehicle that will work for London and is more lightweight than the proposed national specification. This would be for 2 years (plus one potentially) and then purchase the super low floor vehicle.

   7.3 Purchase no vehicles from the national specification for 2 years and then purchase 158 super low floor vehicles in a single year.

   7.4 Develop and procure c.30 low floor lightweight vehicles in year 1 & year 2 to inform national procurement specification for year 3.

   7.5 Refurbishment existing vehicles. There is the option to do a re-mount program or further development can be made in fitting older vehicles with exhaust after treatment for ULEZ compliance. The super low floor vehicle could also be designed on a Euro 6 platform to satisfy the accessibility and light-weighting elements whilst the zero emission capability is engineered.

8. A financial options appraisal is shown below:

Vehicle type	Vehicle numbers by year	Capital cost	Comments
National specification	Y1 – 70 Y2 – 70 Y3 – 18-70 or 70 Zerro	£10.5M £10.5M £2.7M - £10.5M or £12.3M (not scale costs)	Creates variation in operating fleets, issues with vehicle weight, not zero emission or fully accessible.
Derogation of national specification	Y1 – 70 Y2 – 70 Y3 – 18-70 or 70 Zerro	£10.5M £10.5M £2.7M - £10.5M or £12.3M (not scale costs)	Creates variation in operating fleets, issues with vehicle weight as this will not be suitable for B class licence holders and not zero emission or fully accessible.
Zerro	Y1 – 0 Y2 – 0 Y3 - 158	0 0 £28M	Delivery risk dependency on scale up of Zerro. Allows for focussed investment on fleet, IT, mobilise Zerro and to maintain a consistent fleet.
Lightweight vehicles	Y1 – 30 Y2 – 30 Y3 – 98	£4.5M £4.5M £14M	Proves viability of lightweight low floor operating and reduces back end delivery

Recommendation

9. This paper recommends that the trust board approve the following approach:

   9.1 Make no commitment to purchasing new DCAs via the national procurement in FY20/21 and 21/22.

   9.2 Develop and deliver 30 innovative new DCAs in each of FY2020/21 and 2021/22 that are lightweight, low floor and provide value for money.

   9.3 Separately, complete the Project Zerro prototype of a low floor, lightweight, zero tailpipe emission DCA funded by InnovateUK.

   9.4 Procure the remaining DCA volume as low / zero emission capable in FY2022/23.

Ross Fullerton
Director of Strategy, Technology & Development

London Ambulance Service NHS Trust

Assurance report:	**Quality Assurance Committee**	**Date:**	**03/01/2020**

Summary report to:	**Trust Board**	**Date of meeting:**	**28/01/2020**
Presented by:	**Mark Spencer, Non-Executive Director, Chair of Quality Assurance Committee**	**Prepared by:**	**Rita Phul, Corporate Secretary**

Matters for escalation:

- Challenges within the Integrated Urgent Care (IUC) and Emergency Operations Centre (EOC) were considered, acknowledging that the Trust was aware that increased staffing needed to be in place during peak demands. It was noted that a clear implementation plan was in place, aligned with the findings of the Care Quality Commission (CQC) during its recent inspection of these services. The Committee was made aware that the EOC in particular was staffed by a number of younger members of staff and that retention within this age group provided a challenge.

- The Committee noted the risk relating to the health and well-being of Trust staff that could be compromised through the failure of the Trust's occupational health provider to meet the contract specification relating to the immunisations of MMR, Hep B and TB inoculations. Members noted that approximately 2,400 staff were impacted and that there had been an occurrence where a paramedic had refused to attend an incident due to non-vaccination.

Other matters considered:

- Clarity in relation to information sharing was discussed and the need to ensure that the Trust's information governance requirements were being met. The Committee noted the challenge faced by the Trust in relation to some staff members' treatment of confidential documents. It was noted that the majority of information governance breaches experienced by the Trust related to the use of paper record forms and that this would be addressed by the introduction of the electronic patient care records (ePCR).

- Consideration was given to the question of whether paramedics had a personal responsibility to undertake vehicle checks themselves and the importance of ensuring that this was clarified in Trust policies. The Committee noted that paramedics currently undertook vehicle checks ahead of dispatch and that this process would continue until the new Make Ready contract commenced in October 2020, at which point vehicle checks would be undertaken by the Make Ready team.

- Consideration was given to 12 hour shifts operated at the Trust and the impact on safety. The Committee observed that some members of staff commit to more than 3 rotas of 12 hour shifts, resulting in tiredness and potentially impacting the safety of patients. Members

	reflected on anecdotal reports on Facebook of staff feeling exhausted following a 12 hour shift. The Committee recommended that safeguards should be put in place to ensure staff were not able to undertake more than three rotas of 12 hours shifts. • The Chair of the Quality Assurance Committee reflected on the increase in usage of Co-ordinate My Care (CMC), noting that the London Ambulance Service NHS Trust (LAS) was currently performing as the best in London. The Committee noted that this was being promoted actively as a good news story.
Key decisions made / actions identified:	• Committee members noted that funding for the trial of Body Worn Video Cameras (BWVC) was being made available by NHS Improvement/England (NHSI/E) and a funding settlement of circa £175,000 had been indicated for the London Ambulance Service NHS Trust (LAS) to trial BWVC for 12 months, the first phase commencing this financial year (2019/20). The Trust was currently scoping its requirements.
Risks:	• The continuing risk of staff retention within the Integrated Urgent Care (IUC) and Emergency Operations Centre (EOC) was noted. Staffing, particularly in EOC, by a number of younger members of staff led to a challenge in retention. • The risk of a compromise to the health and well-being of Trust staff through the failure of the Trust's occupational health provider to meet the contract specification relating to the immunisations of MMR, Hep B and TB inoculations.
Assurance:	• The Committee noted the positive approach to cardiac arrest, stroke and STEMI patients, noting the improvement in the service, and highlighted the need to share good news stories in the media and particularly with regulators, including the CQC. • The Committee was reassured that a programme was underway, led by the Trust's Occupational Health and Wellbeing Consultant to undertake inoculations across the Trust. The programme was progressing and further reassurance would be provided as the programme continued. • The Committee received a quality impact assessment of Trust plans to use non-frontline paramedics working in core operations during the winter period, which formed part of the financial recovery plan as a new way of working.

London Ambulance Service NHS Trust

Assurance report:	People and Culture Committee	Date:	16/01/2020
Summary report to:	Trust Board	Date of meeting:	28/01/2020
Presented by:	Jayne Mee, Non-Executive Director, People and Culture Committee Chair	Prepared by:	Jayne Mee, Non-Executive Director, People and Culture Committee Chair

Matters for escalation:

- Garrett Emerson, Chief Executive, presented the Civility Review and invited questions and feedback from the Committee. Consideration was given to the action plans and for the organisation to address the cultural and behavioural challenges which the review has highlighted. The Committee agreed that the review should be shared with the Board with a view to deciding how this may feed into a bigger programme of leadership culture work. The Chair of PCC would be happy to provide a recommendation of a suitable organisation to support the work if required.

- The Committee received a presentation of two improvements plans – the Call Handling Improvement Plan and the EOC Improvement Plan which identified themes of leadership, recruitment, retention, training, and sickness absence amongst others. The Committee welcomes the plan and have asked for an update at its July meeting. Consideration was given to the delivery of a full establishment of Paramedics and Emergency Ambulance Crew noting that this would remain a challenge until the operating model had been defined. Members reviewed recruitment numbers noting a requirement to recruit 536 frontline staff in 2020/21, comprising of 136 Trainee Emergency Ambulance Crews (EACs), 200 paramedics and 200 international paramedics. The Paramedic recruitment would ensure 220 people to support PCN's. The Committee noted that delivery of this recruitment would afford 105% establishment, and mean that a further recruitment drive in Australia would take place during April 2020.

Other matters considered:

- Members reflected on the Trust's aspiration to develop a talent management culture, noting that the skills, resource, policies and practices did not currently exist within the organisation. In order to deliver the Trust's People Strategy and the relevant commitments of the 3-year business plan, the Director of People & Culture would be reviewing the structure and capability of the People & Culture directorate. Subject to financial approval and consultation where necessary a revised structure would be implemented that better met the needs of the organisation for the future. The requirements for resources and skills to deliver the talent management strategy would form part of that proposal. If approved, once resources were in place, the Trust would then work to fully enable a Talent Management strategy. The Chair suggested that if the Board

	discussion about Leadership Culture referred to above took place that talent development would be a major part of this and would need early consideration. • The Committee received and noted the quarterly Health and Safety report. • The Committee were updated regarding the Annual Leave Policy which was outdated and did not align to the NHS Agenda for Change (AFC). Consideration was given to the complexity of updating the Annual Leave policy noting the need to undertake significant consultation and engagement. A further update on the way forward would be provided at the PCC meeting in March followed by presentation of the Annual Leave policy to the Committee's meeting in May 2020.
Key decisions made / actions identified:	• Committee members noted the report outlining the specification of requirements secure new providers for Occupational Health and associated Wellbeing Services to include Occupational Health, Physiotherapy, and Employee Assistance Plan (EAP) and Counselling. The Committee recommended to the Chief Executive that this now be moved forward into a tender process with colleagues in procurement in order that new suppliers may be appointed as the previous contract terminates in June 2020. • There was further discussion about the importance of health and wellbeing generally of our people and the report outlined ways in which this could be developed in the Trust. It was noted that this had been a focus of discussion at the last Trust Board development day. The Committee suggested that this should be part of the wide leadership culture programme that was being discussed. • The Committee received a briefing on the implementation of a pilot of body worn cameras. • The Committee discussed the possibilities resulting from Brexit at the end of December 2020 and concurred that the recommendation from the Committee to the Trust Board should be that EU exit was not currently a BAF risk and should be de-escalated from the BAF but remain on the corporate register.
Risks:	• The risk that the Civility Review was looked at in isolation and not correlated as part of a wider leadership culture programme to include staff survey, diversity and talent.
Assurance:	• The Committee received assurance that body worn cameras would be trialled through a pilot in an effort to support our people who find themselves experiencing violence and aggression during the course of their work.

London Ambulance Service NHS Trust

Report to:	**Trust Board**			
Date of meeting:	28 January 2020			
Report title:	Board Assurance Framework and Corporate (Trust Wide) Risk Register			
Agenda item:	11			
Report Author(s):	Frances Field, Risk and Audit Manager			
Presented by:	Philippa Harding, Director of Corporate Governance			
History:	Consideration by Executive Committee and Board Assurance Committees			
Status:	☒	**Assurance**	☒	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

This paper provides the Trust Board with an updated Board Assurance Framework (BAF) and Corporate (Trust Wide) Risk Register (C(TW)RR) January 2020.

Recommendation:

The Trust Board is asked to comment on this report.

Links to Board Assurance Framework (BAF) and key risks:

This paper sets out the content of the BAF and the C(TW)RR.

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☒
Financial	☒
Workforce	☒
Governance and Well-led	☒
Reputation	☒
Other	☒

This paper supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

Board Assurance Framework (BAF)

Current BAF Risks

1. The risks currently on the BAF are set out below in descending order of severity.

Severity	Risk	Risk Owner	Scrutinising Committee	Comments
1.	**BAF Risk 57** There is a risk that the Trust will not deliver the required control total and National Standards whilst maintaining quality of care as a result of potential increased activity and cost pressures in 2019/20 and due to the level of system pressures that are facing commissioners	Lorraine Bewes, Chief Finance Officer	Finance and Investment Committee	
2.	**BAF Risk 56** The Trust's ability to recruit and retain registered clinicians to our core front line operations (a sustainable workforce) will be affected by the changing landscape of the NHS which opens opportunities for paramedics to be employed in other healthcare setting and which will impact our ability to meet operational targets	Ali Layne-Smith, Director of People and Culture	People and Culture Committee	
3.	**BAF Risk 45** A cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period.	Ross Fullerton, Chief Information Officer	Logistics and Infrastructure Committee	
4.	**BAF Risk 54** There is a risk that the Trust will not be able to meet KPI's within its 111/IUC contracts as a result of challenged specialist trained resource requirements and performance which may result in the Trust not fully delivering its strategy.	Khadir Meer, Chief Operating Officer	Quality Assurance Committee	
5.	**BAF Risk 53** There is a risk that the normal business continuity arrangements followed by the Trust will need to be enhanced in the event of a no deal departure from the EU due to the unknown nature and extent of the potential disruption to business.	Khadir Meer, Chief Operating Officer	Finance and Investment Committee	

BAF Risk 57

2. The Finance and Investment Committee is due to consider papers relating to BAF Risk 57 at its meeting on 21 January 2020. An oral update can be provided at the Board meeting on 28 January 2020.

BAF Risk 56

3. The People and Culture Committee meeting on 16 January 2020 received an oral update on Strategic Workforce Planning and the key areas of work currently being undertaken, including the integration of the Integrated Urgent Care service and the 999/Ambulance Service. It was noted that Pauline Cranmer, Director of Ambulance Services, was also leading a programme of work in relation to the development of a new patient facing operating model.

BAF Risk 45

4. The Logistics and Infrastructure Committee meeting on 14 January 2020 received its regular update on work being undertaken in relation to this risk. Members acknowledged that there was clearly a lot of work being undertaken to address cyber security challenges; however the changing nature of reporting on this meant that it was challenging for the Committee to monitor the effectiveness of this work and take assurance in a consistent way. It was noted that Committee members required further assurance and would welcome a more concrete dashboard. Reference was made to the GCHQ's National Cyber Security Centre's Cyber Assessment Framework (NCSC CAF), a cyber resilience assessment designed to allow organisations to 'achieve and demonstrate' their cyber resilience as well as guide their efforts to improve cyber security. The Committee was informed that the Cyber team had undertaken an assessment of the Trust against the NCSC CAF. It was noted that training in the use of the framework was being arranged for an informal Trust Board development session to support Non-Executive Directors in ensuring effective use of the tool to gain assurance in relation to cyber security.

BAF Risk 54

5. The Quality Assurance Committee meeting on 09 January 2020 took some assurance in relation to this risk from the Quality Report and an additional oral update on Trust performance over the Christmas and New Year period. Challenges within the Integrated Urgent Care (IUC) and Emergency Operations Centre (EOC) were considered, acknowledging that the Trust was aware that increased staffing needed to be in place during peak demands. It was noted that a clear implementation plan was in place, aligned with the findings of the CQC during its recent inspection of these services.

BAF Risk 53

6. The People and Culture Committee discussed this risk at its meeting on 16 January 2020. The Committee noted that a withdrawal agreement was now in place and discussed the possibilities resulting from the need to secure a trade agreement by the end of December 2020. Committee members agreed to recommend to the Trust Board this risk should not be considered a BAF-level risk at this current time and therefore it should be de-escalated from the BAF, with a view to being reviewed in October 2020. It is anticipated that this risk will continue to be a highly rated Corporate (Trust Wide) Risk.

7. The Trust Board is asked to confirm that it approves the de-escalation of this risk from the BAF.

Proposed new additional BAF Risk

8. At its meeting on 14 January 2020, the Logistics and Infrastructure Committee received a report on the status of the Trust's Uninterruptable Power Supply (UPS), noting the requirement for corrective actions to be completed in concert with Operations at Bow and Waterloo. The Committee observed that an independent inspection undertaken at the Waterloo site had identified that the age, condition, capacity and fitness for purpose of the power management system had highlighted a significant risk of service interruption and failure. It was noted that the UPS system at Waterloo comprised of two UPS units of differing age and were not functioning as a parallel pair correctly as the communications cards in both units had become defective. There was a significant risk noted that if one unit suffered an outage, the electrical supply to critical loads would be lost. An independent inspection at the Bow site had identified that whilst outstanding challenges continue with regard to the UPS risk, the risk to the Waterloo site was greater. Consideration was given to the unplanned cost of the remedial works.

9. The Committee reflected on previous discussions in relation to the UPS challenge, noting assurances that had been provided. Consideration was given to escalating the risk associated with the failure of the UPS to the BAF. It had previously been proposed by the Executive Committee that a wider infrastructure risk be escalated to the BAF. The Committee considered this an appropriate approach and the Chair of the Committee welcomed an update from the Executive with regard to the progress of mitigating this risk. Further information about this proposed new additional BAF Risk can be found attached in Annex A to this report.

10. The Trust Board is asked to confirm that it approves the additional of the following risk to the BAF:

    - There is a risk that the power management infrastructure at Bow and Waterloo is either not fit for purpose presenting a single point of failure, or old and requiring replacement. This may in the event of a power supply issue result in failure that will see disruption to EOC and frontline service delivery.

11. The Committee requested that a lessons learned report be completed with regard to the situation relating to the weaknesses of the UPS and their mitigation. Members reflected on a recent report presented to the Board regarding learning outcomes resulting from challenges faced by the Integrated Urgent Care service. The Committee welcomed a similar report in relation to the UPS challenge.

Corporate (Trust Wide) Risks

Highly-rated Corporate (Trust Wide) Risks not included on the BAF

12. The following risks currently have a rating of 15 or greater, which are not included on the BAF:

    - Datix ID 706 – EOC training have limitations on space and building facilities which may impact ability to deliver training; there is a risk that insufficient capacity and/or site conditions could cause interruption to training courses.
    - Datix ID 844 - There is a risk of project slippage due to an undefined technical solution (Kit prep / Wi-Fi) for medicines packing and management at Logistics Support Unit Deptford. This may lead to the maintenance of paper based systems and poor data collection if not properly managed.
    - Datix ID 945 - There is a risk to the integrity of the data being produced by Kitprep due to the system not working as expected which leads to inaccuracy in the Perfect Ward audit tool of expiry dates of drug packs and discrepancies when reconciling the number of drug packs with the system.

- Datix ID 967 - There is a risk that patient experience will be adversely impacted at specific times of the week as a result of the lack of flexibility within the current Annual Leave agreement in place within operations resulting in a significant drop in the number of available staff and longer patient waiting times.
- Datix ID 872 - There is a risk that the health and well-being of our staff may be compromised through the failure of our occupational health provider to ensure that all staff have appropriate immunisations due to lack of accurate staff records and lack of nursing resource from PAM to carry out immunisations which could lead to staff being exposed to infection or staff declining to attend jobs where there is risk of infection which could impact on performance.
- Datix ID 973 - There is a risk that ambulance premises, operational ambulance fleet and other LAS assets may be accessed by unauthorised persons because of inadequate physical security arrangements, which may lead to damage and/or loss of assets which are critical for the delivery of the care and patient safety patients, unplanned financial costs for the repair/replacement and damage the reputation of the Trust if not properly managed.

Corporate (Trust Wide) Risk progress since the BAF was considered by the Board on 26 November 2019

Datix ID 706 - EOC training have limitations on space and building facilities which may impact ability to deliver training; there is a risk that insufficient capacity and/or site conditions could cause interruption to training courses.

13. This risk was reviewed by the 999 Operations Quality Group on 09 January 2020. As a location has been secured at Barking from end of January and the Southwark Bridge Road lease has been extended to December 2020 with a one month break clause, the proposal has been made to reduce the score of this risk to possible/major = 12. This will be considered by the Risk, Compliance and Assurance Group (RCAG) at its meeting on 30 January 2020.

Datix ID 844 - There is a risk of project slippage for medicines packing and management at Logistics Support Unit Deptford. This may lead to the maintenance of paper based systems and poor data collection if not properly managed.

Datix ID 945 - There is a risk to the integrity of the data being produced by Kitprep due to the system not working as expected which leads to inaccuracy in the Perfect Ward audit tool of expiry dates of drug packs and discrepancies when reconciling the number of drug packs with the system.

14. The Ethernet adapters for the iPads to resolve the connectivity issues have been installed at LSU which has resolved the connectivity issues. A full user acceptance testing (UAT) including functional and non-functional has been completed.

15. The UAT for the Kit Prep App commenced in December and will complete 31/01/2020. The Trust has made a decision to proceed with the development of Kit Prep2 which should address the issues around data integrity and provide a more robust approach to tracking and tracing medicines

Datix ID 967 - There is a risk that patient experience will be adversely impacted at specific times of the week as a result of the lack of flexibility within the current Annual Leave agreement in place within operations resulting in a significant drop in the number of available staff and longer patient waiting times.

16. Datix ID 967 was considered by the RCAG at its meeting on 08 January 2020, where RCAG members discussed the age of the risk and its appropriateness, it was concluded that, as the appropriateness of the Annual Leave Policy remains a subject of consideration for the Executive, it is appropriate for the risk to be held and that the score reflected the position. It

should be noted that the drafting of this risk has been amended to reflect the fact that it is patient experience, rather than patient safety which is its focus.

Datix ID 973 - There is a risk that ambulance premises, operational ambulance fleet and other LAS assets may be accessed by unauthorised persons because of inadequate physical security arrangements, which may lead to damage and/or loss of assets which are critical for the delivery of the care and patient safety patients, unplanned financial costs for the repair/replacement and damage the reputation of the Trust if not properly managed.

17. Datix ID 973 was considered by the RCAG on 08 January 2020, where RCAG members noted that the Care Quality Commission (CQC) report had identified a 'Must Do' action in respect of this issue and that the risk should be reviewed and assessed in line with the CQC's requirements to ensure that access to stations are secure and vehicle security are considered.

18. The Logistics and Infrastructure Committee received a report (ref LIC/19/85) at its meeting on 14 January 2020, providing assurance in relation to the extensive work being undertaken to review and regularise management of estates compliance, the estates team was able to clearly demonstrate improvements and whilst there is still work to do, the focus being applied is improving the risk profile of the Trust in relation to its regulatory position. The Logistics and Infrastructure Committee considered at on 14 January 2020 whether this risk should be escalated to the BAF and agreed that this was not necessary at the current time.

Datix ID 872 - There is a risk that the health and well-being of our staff may be compromised through the failure of our occupational health provider to ensure that all staff have appropriate immunisations due to lack of accurate staff records and lack of nursing resource from PAM to carry out immunisations which could lead to staff being exposed to infection or staff declining to attend jobs where there is risk of infection which could impact on performance

19. Datix ID 872 was considered by the RCAG on 08 January 2020 and particular reference was made to data accuracy in respect of immunisation and vaccination of international paramedics and the impact that non vaccination might have on LAS staff attendance and availability. Members agreed that the immunisation and vaccination of staff, particularly the international paramedic cohort should be escalated and the risk, its controls and mitigations should be revised to ensure that this is appropriately captured.

20. The risk was further discussed by the Quality Assurance Committee (QAC) on 09 January 2020, where the Committee was told that a programme was underway, led by the Trust's Occupational Health and Wellbeing Consultant to undertake inoculations across the Trust. The Committee sought assurance that the programme was progressing and requested a report on this to be shared with both the People and Culture Committee and the Quality Assurance Committee.

Horizon scanning

21. At the informal Trust Board Strategy/Briefing/Development meeting on 17 December 2019 (ref: TBD/19/30), the Board considered the following horizon scanning questions:

- What would be the worst thing that could happen right now / tomorrow?
- What is your greatest fear for the organisation in the next 12–36 months?
- What is the greatest challenge for the organisation in the next 12–36 months?
- What is the greatest opportunity the organisation has in the next 12-36 months?

22. Board members flagged the following issues that are being investigated further and will be reported on at the next meeting of the Trust Board in public.

- Risks to the achievement of proposed draft 3 year Business Plan objectives

- Potentially unprecedented and sustained increase in volume of calls being received by the organisation
- Implementation and embedding of learning from recent major incidents
- Infrastructure risks, particularly in light of their link to the Computer Aided Dispatch (CAD) system
- Risks to the health and wellbeing of staff members, particularly the risk of suicide associated with the role of paramedic
- Financial sustainability
- Talent management
- Continuing to operate as a pan-London influencer in order to achieve the Trust's vision
- Embedding cultural change
- Succession planning and staff engagement (making sure that staff are heard by the Board)

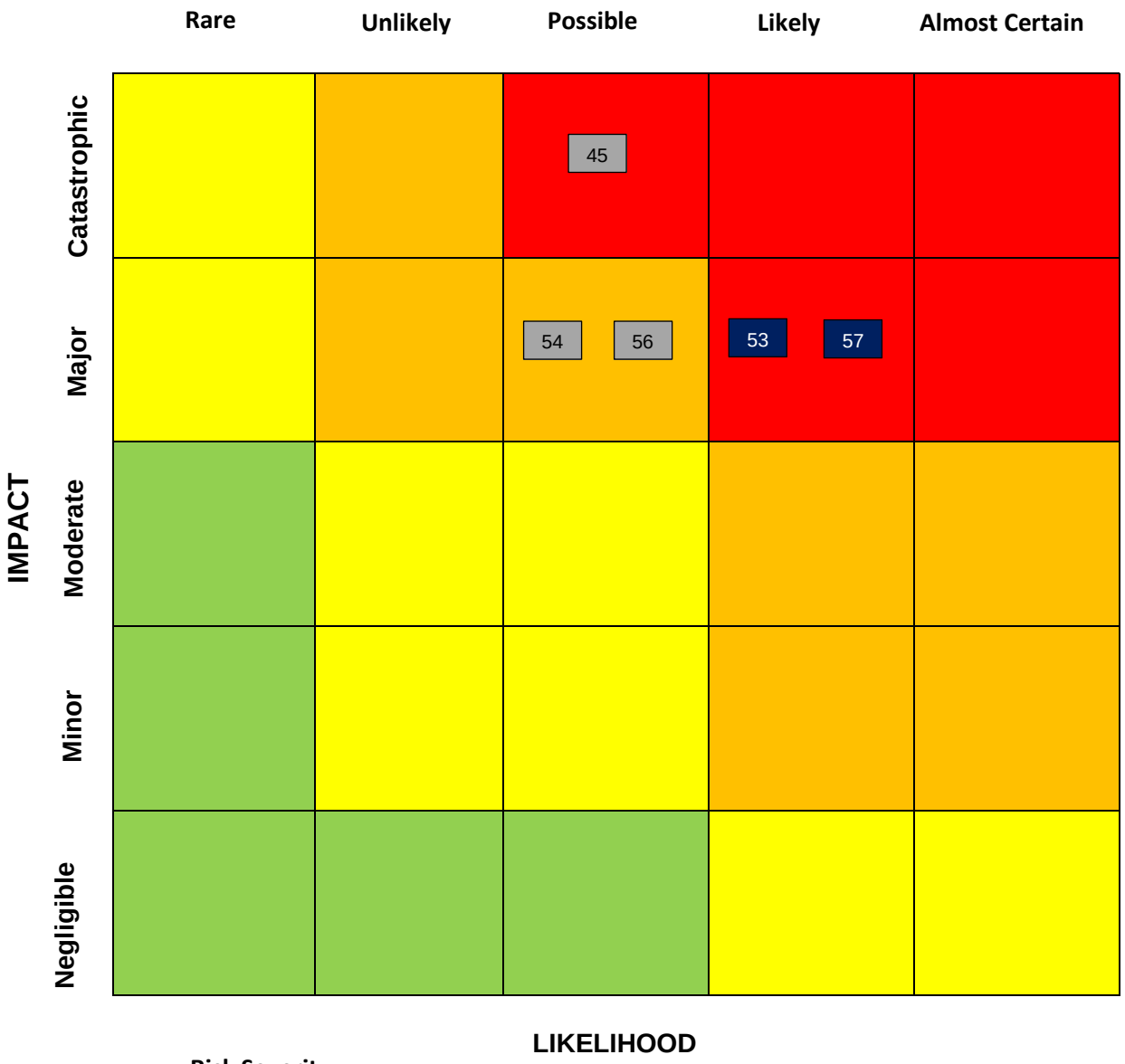
Risk Appetite

23. Information about the Trust's current Risk Appetite can be found on page 2 of the BAF (attached). At the informal Trust Board Strategy/Briefing/Development meeting on 17 December 2019 (ref: TBD/19/30), the Board considered whether this remained appropriate.

24. Board members considered whether risk categories should continue to align to the Good Governance Institute risk categories, or whether they should align to a classification of strategic objectives. Consideration was also given to the question of whether risk appetite should be re-visited in some areas, with a greater appetite being articulated in relation to certain issue. It was also suggested that a distinction should be made between "business as usual" activities and "strategic change-related/innovative" activities. Further work is being undertaken on this and will be presented to the next meeting of the Audit Committee ahead of its presentation to the Trust Board meeting on 31 March 2020.

Frances Field
Risk and Audit Manager

Board Assurance Framework – January 2020



In order of severity:

BAF Risk 57
There is a risk that the Trust will not deliver the required control total and National Standards whilst maintaining quality of care as a result of potential increased activity and cost pressures in 2019/20, and due to the level of system pressures that are facing commissioners.

BAF Risk 56
The Trust's ability to recruit and retain registered clinicians to our core front line operations (a sustainable workforce) will be affected by the changing landscape of the NHS which opens opportunities for paramedics to be employed in other healthcare setting and which will impact our ability to meet operational targets.

BAF Risk 45
A cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period.

BAF Risk 54
There is a risk that the Trust will not be able to meet KPI's within its 111/IUC contracts as a result of challenged trained specialist trained resource requirements and performance which may result in the Trust not fully delivering its strategy.

BAF Risk 53
There is a risk that the normal business continuity arrangements followed by the Trust will need to be enhanced in the event of a no deal departure from the EU due to the unknown nature and extent of the potential disruption to business.

Risk Severity

- High Risk (15-25)
- Significant Risk (8-12)
- Moderate Risk (4-6)
- Low Risk (1-3)

Key

- Net risk rating
- Gross risk rating = net risk rating

Risk Appetite Statement

The London Ambulance Service NHS Trust (LAS) recognizes that its long term sustainability depends upon the delivery of its strategic ambitions and its relationships with its patients, people, public and partners. As such, LAS will not accept risks that materially provide a negative impact on the quality/outcomes of the care it provides.

However, LAS has a greater appetite to take considered risks in terms of their impact on organisational issues. As such, LAS has a greater appetite to pursue Financial/Value for Money and Reputational risks and has a high risk appetite for innovation (clinical and financial) in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.

Key Risk Categories – risk appetite and risk tolerance scores

Risk Category	Link to 4 Ps in LAS strategy	Risk Appetite	Risk Appetite Score
Quality/ Outcomes	Patients	LAS has a LOW risk appetite for risks that may compromise the delivery of outcomes for patients.	6-10
Reputation	Partners Public	LAS has a MODERATE risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the organisation.	12-16
Innovation (clinical & financial)	Partners Our People	LAS has a HIGH risk appetite for innovation that does not compromise quality of care.	20-25
Financial/VFM	Partners Public	LAS has a MODERATE risk appetite for financial/VFM risks which may ensure the achievement of the organisation's strategy whilst ensuring that the risk of financial loss is minimised and statutory requirements are complied with.	12-16
Compliance/ Regulatory	Partners Our People	LAS has a LOW risk appetite for Compliance/Regulatory risk which may compromise the Trust's compliance with its statutory duties and regulatory requirements.	6-10

GOAL 1 **Provide outstanding care for our patients**	**DELIVERABLE** 1. We will deliver the key deliverables in our Quality Plan for 2018/19 to improve patients' experience and quality of care for patients using our service. 2. We will deliver our post-ARP transformation plan to ensure we can meet national performance and quality standards. 3. We will continue the roll-out of our urgent care Advanced Paramedic Practitioner service across all five STP areas to improve patient care and reduce the need for patients to go to hospital and develop a new paramedic practitioner role. 4. We will complete our new five-year strategy document and publish new or revised 'daughter documents' containing detailed plans on how we will deliver it. 5. We will pilot the new 'Pioneer Services' set out in our new strategy. 6. We will implement a 'frequent caller plan' to improve the care we provide those patients to better meet their needs and reduce the impact of their calls on our wider patient response times. 7. We will continue to improve the quality and security of our drug management through the roll-out of our Secure Drugs Room project, primary response bags, vehicle based drugs pack, internal order drug system and enabling applications. 8. We will improve the quality of care we deliver to patients and our work with partners across the system by introducing new capability that builds on the roll out of iPads to our front-line clinicians.

Links to Deliverables	BAF Risk	**Further mitigation required**
1.	53. There is a risk that the normal business continuity arrangements followed by the Trust will need to be enhanced in the event of a no deal departure from the EU due to the unknown nature and extent of the potential disruption to business.	• Link any cost variances in supply chain to be included in budget setting requirements. (no longer required due to the approval by parliament of the Withdrawal Agreement Bill, which includes a planned 11-month transition period)
1, 4	54 There is a risk that the Trust will not be able to meet KPI's within our 111/IUC contracts as a result of challenged specialist resource requirements and performance which may result in us not fully delivering our strategy.	• The development of an internal LAS bank contract for advanced practitioners and GP's. • The commissioning of a simulation software has been approved by ExCo which will enable a better understanding of staffing requirements and skill mix to achieve optimum performance and safety. • Development of productivity measures to add to the performance score card to ensure oversight of productivity. • Forecasting and Planning Team are developing an initial forecasting model to improve planning of health advisor staffing.

GOAL 2 **Be a first class employer, valuing and developing the skills, diversity and quality of life or our people**	**DELIVERABLE** 9. We will complete our recruitment plan to fully establish our front-line and newly enlarged Emergency Operations Centre structures. 10. We will complete the restructuring and recruitment to our main organisational directorates, changing the way we operate, 11. We will embed our new Vision, Purpose, Values and Behaviours (set out in our new strategy document) across the organisation and fully align our competencies to the employee journey at LAS in: recruitment, promotion, training and development and appraisals. 12. We will complete action plans across all functional and operational areas of the business to respond to the key issues identified in the 2017 Staff Survey and implement the planned actions in time for the 2018 Staff Survey. 13. We will continue to deliver our Workforce Race Equality Standard (WRES) Action Plan, together with other measures, to improve diversity, inclusivity and equality across all areas of the organisation. 14. We will continue to implement our Clinical Education Strategy. 15. We will develop and roll-out training and development for all our people across functional and operational teams.

Links to Deliverables	BAF Risk	**Further mitigation required**
9	**56** The Trust's ability to recruit and retain registered clinicians to our core front line operations (a sustainable workforce) will be affected by the changing landscape of the NHS which opens opportunities for paramedics to be employed in other healthcare setting and which will impact our ability to meet operational targets	• Determine skill mix to support patient requirements and operational delivery within the financial budget available. • Establish a skills mix that will meet the demand profile of the Trust with a realistic reliance on paramedic numbers

GOAL 3	Partner with the wider NHS and public sector to optimise healthcare and emergency services provision across London	**DELIVERABLE** 16. We will continue to work with our commissioners and STP partners to lower demand, improve access to, and use of, Appropriate Care Pathways (ACPs) and lower overall conveyance to Emergency Departments, developing the use of technology to provide faster access to patient care through digital means where appropriate. 17. We will mobilise the North East London Integrated Urgent Care (111) contract and continue to seek a greater role in the London-wide integration of access to emergency and urgent care, including retaining the South East London 111 service. 18. We will work closely with London acute hospital trusts, NHSI and NHSE to further reduce delays to patients and our crews at hospitals, especially during times of peak pressure on the wider system (e.g. during periods of high demand such as adverse weather). 19. We will work closely with other emergency services and partners (e.g. the Greater London Authority family and London's boroughs), fulfilling our statutory obligations to collaborate, innovate and maximise the efficiency of our combined public service provision.

Links to Deliverables	BAF Risk	**Further mitigation required**
17	54 There is a risk that the Trust will not be able to meet KPI's within our 111/IUC contracts as a result of challenged specialist resource requirements and performance which may result in us not fully delivering our strategy.	• The development of an internal LAS bank contract for advanced practitioners and GP's. • The commissioning of a simulation software has been approved by ExCo which will enable a better understanding of staffing requirements and skill mix to achieve optimum performance and safety. • Development of productivity measures to add to the performance score card to ensure oversight of productivity. • Forecasting and Planning Team are developing an initial forecasting model to improve planning of health advisor staffing.

GOAL 4	**Provide the best possible value for the tax paying public, who pay for what we do**	**DELIVERABLE**	20. We will deliver our control total and maintain our use of resources rating with NHSI. 21. We will deliver Cost Improvement Programme (CIP) efficiency savings of £12.3m in 2018/19 and develop a programme of further efficiencies to inform our business planning for 2019/20 and 2020/21. 22. We will complete the review of business resilience across the organisation and implement measures to effectively manage risk and ensure the continuity of our services during times of disruption, including GDPR compliance and Cyber risk assurance. 23. We will manage and deliver our proposed capital programme of £15.5m to support the delivery of our overall strategic objectives. **24.** We will ensure the delivery of our agreed CQUIN's (as agreed with our core contract commissioners) to improve the quality and value of the services we provide on their behalf.

Links to Deliverables	BAF Risk	Further mitigation required
20	57. There is a risk that the Trust will not deliver the required control total and National Standards whilst maintaining quality of care as a result of potential increased activity and cost pressures in 2019/20 and due to system pressures that are facing our commissioners.	• Continue to track progress and implement any residual actions from IUC improvement plan. • Continue to track progress and implement any residual actions from 111 improvement plan. • Identify additional savings required in light of future shortfall on (1&2) above.

22	45 There is a risk that a cyber- attack could materially disrupt the Trust's ability to operate for a prolonged period.	• GHCQ accredited SIRO training
		• Deliver the 19/20 the cyber projects (as detailed below): On Target
		  • Secure Email (NHSmail) – Potentially delivering as further benefits or separately:
		  ○ Single-Sign-On (SSO)
		  ○ Identity Management (IdM)
		  • Security Information & Event Management (SIEM)
		  • Network Segregation
		• Deliver Executive level NCSC Cyber Awareness training with commensurate IR exercise
		• Leverage NHSD funded training opportunities to develop in-house cyber capabiltiy
		• Rescope the Cyber Programme to deliver the outcome of holistic DSPT compliance

BAF Risk no. 57 There is a risk that the Trust will not deliver the required control total and National Standards whilst maintaining quality of care as a result of potential increased activity and cost pressures in 2019/20 and due to the level of system pressures that are facing commissioners.

Risk Classification: Finance	**Risk Owner:** Lorraine Bewes	**Scrutinising Committee:** Finance & Investment Committee
Date risk opened: 19/06/19	**Date risk expected to be removed from the BAF:** March 2020	
Change since last review:	3 actions were completed, relating to funding from commissioners and risk share on the 2019/20 contract	

Underlying Cause/Source of Risk:	**Gross Rating**	**Current/Net Rating**	**Target Rating**
The Trust has set a 19/20 plan to realise a balanced control total which also assumes delivery of national performance standards. A number of potential cost pressures have been identified in year which were not included in the original plan.	**16**	**16**	**8**

Existing Controls	**Positive Assurance of Controls**
1. Comprehensive resource model developed which links workforce, frontline fleet capacity, finance, and demand to forecast ability to deliver national response performance standards. 2. Heads of Terms agreed with Commissioners with Hear & Treat increases and timing of delivery of national performance standards still being agreed before the contract can be signed. 3. CIPs managed through business planning/programme office, improved governance remains in place to ensure effective identification, implementation and tracking of CIPs in 2019/20. 4. Recruitment and retention to clinical posts is a key area of focus to secure permanent clinical workforce required 5. A 999 operational improvement and recovery plan to ensure delivery of national performance trajectories agreed with commissioners within resources available has been developed and is being tracked weekly. (There are still ongoing problems with the recruitment of paramedics). 6. The service has produced and is implementing an IUC recovery plan with interventions including rostering to meet demand and is being tracked weekly. 7. Agreed scope of application of the revised banding which applies to both EAC and TEAC staff groups and will cost £4.1m for 19/20 (7m 20/21) 8. Contract risk share has been agreed 9. The Trust has identified sufficient recurrent CIPs for 2019/20. **Gaps in Controls** 1. Formal terms of reference for the IUC performance meetings are yet to be agreed 2. Trust Board to approve formal financial recovery plan.	• Monthly finance reports to the ExCo and the Finance and Investment Committee • Bi-monthly Integrated Performance Reports to the Trust Board • YTD Incident levels remain above contract threshold levels • Integrated Urgent Care recover plan will be tracked through the Integrated Urgent Care Programme Board and monthly financial reporting to the FIC, ExCo. • The operational improvement plan will be tracked through weekly operational performance meetings.

Further Actions	**Responsible Person/s**	**Due Date**
1. Continue to track progress and implement any residual actions from IUC improvement plan.	1. James Corrigan, Financial Controller / Athar Khan, Director of Integrated Patient Care	March 2020
2. Continue to track progress and implement any residual actions from 111 improvement plan.	2. James Corrigan, Financial Controller / Athar Khan, Director of Integrated Patient Care	March 2020
3. Identify additional savings required in light of future shortfall on (1&2) above.	3. Ellie Horne, Financial Recovery Director	March 2020

Signed: Lorraine Bewes, Chief Finance Officer

BAF Risk no. 53 There is a risk that the normal business continuity arrangements followed by the Trust will need to be enhanced in the event of a no deal departure from the EU due to the unknown nature and extent of the potential disruption to business

Risk Classification: Finance	Risk Owner: Pauline Cranmer	Scrutinising Committee: Finance & Investment Committee
Date risk opened: 17 January 2019	Date risk expected to be removed from the BAF:	
Change since last review:	Actions, controls and assurances updated since review at EU Exit Preparedness Group Meeting on 24 October 2019	

Underlying Cause/Source of Risk: The Trust has carried out a comprehensive review of its preparedness for a departure from the European Union on a worst case basis and has considered risks to supply chain, business continuity and emergency preparedness, workforce, drugs and other more general risks including regulatory risks taking into account all of its services including 999 / 111 / IUC.	Gross Rating	Current/Net Rating	Target Rating
	16	16	8

Existing Controls	Positive Assurance of Controls
1. The Trust has conducted its assessment of the risks faced by the Trust in the event of a worst case departure from the EU on 31 October 2019, in line with the framework mandated by the Department of Health and Social Care. 2. The Trust's standing orders allow for urgent decisions to be taken when necessary. 3. The Trust has business continuity plans in place which are being tested in the context of hypothetical EU exit scenarios. 4. The Trust has mapped the supply chain for medical consumables and all the Trust's suppliers have a UK depot. Four key suppliers would hold 3 months' worth of stock on UK soil. 5. Fuel stocks confirmed which address the civil contingency act requirement to supply 20 days' supply. 6. A fuel monitoring system is installed and working to protect fuel stocks. 7. Fuel management plan in place- (continuity) aligned to the national arrangement for fuel distribution co-ordinated by NARU – NACC 8. Local business continuity plans reviewed and updated to ensure EU response ready. 9. Annual leave for Directors and direct reports is now available through GRS, providing visibility of senior staff availability. 10. The communications plan has been refreshed by the Communications Team and made available to staff. **Gap in controls** The Trust is the only ambulance service that relies almost entirely on pump fuel and would therefore be particularly exposed during a fuel shortage. The Trust cannot change the configuration of its fuel supply and is reliant on the national priority list for the provision of fuel in the event of a shortage.	1. Exit from the EU to be a standing item on the Executive Committee agenda going forward. 2. A focus group is in place which is meeting fortnightly providing feedback to the Executive Committee on the actions being taken to manage any risks identified with standing reports on logistics, fleet parts and fuel, procurement, drugs supplies including Frimley Park, communications and EPRR and Business Continuity. 3. The Trust has identified a Director to be the Senior Officer responsible for the Trust's preparedness for the UK's exit from the EU. 4. The Trust has been advised they are considered a priority service by the government for the supply of fuel in the event of a shortage. 5. IUC/111 clinicians in the CAS are receiving increased requests for longer prescriptions which is being mitigated through a medicines bulletin being sent to staff. 6. Internal audit review noted significant areas of assurance from the implementation of focus groups, executive leadership and business continuity plans in place. 7. The Trust has clarified and agreed its SECAMB mutual aid that was requested.

Further Actions	Responsible Person/s	Due Date
1. Link any cost variances in supply chain to be included in budget setting requirements. (no longer required due to the approval by parliament of the Withdrawal Agreement Bill, which includes a planned 11-month transition period)	1. James Corrigan, Financial Controller	

Signed: Pauline Cranmer, Director of Ambulance Services

BAF Risk no. 45 There is a risk that a cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period

Risk Classification: IM&T	**Risk Owner:** Ross Fullerton	**Scrutinising Committee:** Logistics & Infrastructure Committee
Date risk opened: 01/06/2017	**Date risk expected to be removed from the BAF:** Ongoing	

Change since last review:

- NHS Digital (NHSD) are proposing that Cyber Essentials Plus requirement becomes DSPT compliance with IT helath check as equivalent
- Centrally funded/provisioned NHSD security capabilities reviewed – training, audit and advisory engaged. Technical solutions available not yet applicable to LAS
- IT infrastructure refresh ongoing to reduce exposure to vulnerabilities
- Patching

Underlying Cause/Source of Risk: The changing sophistication and nature of cyber threats poses a risk to the Operation of all technology dependant organisations including the LAS. The Trust has established an ongoing cyber programme to identify and address gaps in technology and business cyber risk mitigation.

Gross Rating	Current/Net Rating	Target Rating
20	15	10

This risk has now been assessed against GCHQ's National Cyber Security Centre's (NCSC) Cyber Assessment Framework for cyber resilience, allowing the Trust to not just measure rigid compliance with the Data Security & Protection Toolkit (DSPT) but holistic application of NCSC's 14 Principles. Management of this risk now focuses on tactical remediation in parallel with strategic change projects to address identified issues and vulnerabilities across four focus areas; applications, infrastructure, people and resilience. To supplement this activity the LAS has also accessed centrally funded resources through NHSD so as to accelerate improvements in cyber maturity and provide additional assurance.

Existing Controls

1. Perimeter controls, endpoint hardening and other technical detection and remediation solutions
2. The continuation of a professional cyber team as a managed service
3. Monitoring robust cyber security KRIs/KPIs for compliance/trends (reported to IM&T SMT and monthly CEO performance review)
4. Auditable set of documents covering people, processes, procedures and tehcnical controls; reviewed by NHSD and third parties at least twice a year
5. Prioritised tactical remediation of identified vulnerabilities and audit improvement points driven by Cyber Team and reported to L&IC quarterly
6. Broad set of real-time security reporting and alerting with ability to take immediate action

Gaps in Controls

1. Specific gaps in Controls are documented in the action plans and the Programme which are monitored at L&IC.
2. Delivery of cyber incident exercise plan to corporate directorates.
3. Closing out use of legacy infrastructure and applications.

Positive Assurance of Controls

1. Cyber Reports to Information Governance Group of cyber-related incidents each quarter
2. Use of NHSD led audit and healthcheck intiatives against Cyber Essentials Plus and the DSPT
3. Additional NHSD assurance support through CORS programme
4. CareCert notifications performance measured and reported as part of the IM&T's KPIs (reported to IM&T SMT and ExCo monthly)
5. Reporting of action plan progress at LI&C and Board

Gaps in Assurance

- NHSD are developing the DSPT to provide equivalence for Trusts to CE+ this is not yet complete.
- Cyber team implementing own vulnerability assessment capability to better assure closure of technical vulnerbailities.

Further Actions	Responsible Person/s	Due Date
1. GHCQ accredited SIRO training	1. Vic Wynn, Head of IM&T Strategy Security & Architecture	1. Complete
2. Deliver the 19/20 the cyber projects (as detailed below): On Target • Secure Email (NHSmail) – Potentially delivering as further benefits or separately: ○ Single-Sign-On (SSO) ○ Identity Management (IdM) • Security Information & Event Management (SIEM) • Network Segregation	2. Vic Wynn, Head of IM&T Strategy Security & Architecture	2. June 2020
3. Deliver Executive level NCSC Cyber Awareness training with commensurate IR exercise	3. Vic Wynn, Head of IM&T Strategy Security & Architecture	3. Jan 2020
4. Leverage NHSD funded training opportunities to develop in-house cyber capabiltiy 5. Rescope the Cyber Programme to deliver the outcome of holistic DSPT compliance	4. Vic Wynn, Head of IM&T Strategy Security & Architecture	4. Jan 2020

Signed: Ross Fullerton

BAF Risk no. 54 There is a risk that the Trust will not be able to meet KPI's within our 111/IUC contracts as a result of challenged specialist resource requirements and performance which may result in us not fully delivering our strategy

Risk Classification: Operational / Corporate	**Risk Owner:** Khadir Meer	**Scrutinising Committee:** Quality Assurance Committee
Date risk opened: 05/03/2019	**Date risk expected to be removed from the BAF:** End October 2019	
Change since last review:	Performance improvements are being maintained on track to remove the risk end October 2019.	

Underlying Cause/Source of Risk: Ability to recruit and retain advanced clinical medical staff such as GPs. Call answering 96% within 60 seconds, call abandonment <2% in NEL / <5% SEL.

Gross Rating	Current/Net Rating	Target Rating
16	12	8

Existing Controls	Positive Assurance of Controls
1. Daily monitoring of metrics including safety. 2. Clinical escalation plan developed and implemented 3. Executive oversight – direct reports meetings. 4. Thematic review of incidents and complaints weekly reflected in monthly quality report. 5. Improvement plan developed and being delivered using agile techniques. 6. Revised forecast and planning modelling to improve resource productivity and capacity particularly at weekends. 7. Scrutiny through both internal and external committees, QOG, QAG, CQRG. 8. Baseline inspection and review against CQC KLOE's which have informed a comprehensive action plan. 9. Agile approach to the mitigation of risks in place. 10. Baseline inspection and review against CQC KLOE's which have informed a comprehensive action plan. 11. Phased approach to implementation of SEL based on learning identified during the NEL mobilisation. 12. Secured the support of regulators and commissioners in identifying further potential sources to recruit and retain medical staff within the CAS. 13. Additional capacity and capability engaged to assist in the delivery of the improvement plan.	• Daily performance report published to executives / commissioners. • Plan signed off by Medical Director. • IUC delivery, standard agenda item at ExCo meetings. • Evidence of completed actions stored on x drive. • Minuted meetings • NEL IUC has had additional performance management measures (put in place by NEL commissioners and HLP/NHSE) lifted in line with improved performance and is now subject to routine contractual performance management. • We are in the process of developing a plan to address current agency costs overspend while maintaining focus on KPI delivery.

Further Actions	Responsible Person/s	Due Date
1. The development of an internal LAS bank contract for advanced practitioners and GP's.	1. Julie Cook, HR Business Partner for Integrated Urgent Care	March 2020
2. The commissioning of a simulation software has been approved by ExCo which will enable a better understanding of staffing requirements and skill mix to achieve optimum performance and safety.	2. Nic Daw, Head of IUC Development	End Jan 2020
3. Development of productivity measures to add to the performance score card to ensure oversight of productivity.	3. Paul Cook, Head of IUC Performance	End Jan 2020
4. Forecasting and Planning Team are developing an initial forecasting model to improve planning of health advisor staffing.	5. Chris Nightingale, (job title?)	March 2020

Signed: Khadir Meer, Chief Operating Officer

BAF Risk no. 56 The Trust's ability to recruit and retain registered clinicians to our core front line operations (a sustainable workforce) will be affected by the changing landscape of the NHS which opens opportunities for paramedics to be employed in other healthcare setting and which will impact our ability to meet operational targets

Risk Classification: Human Resources	**Risk Owner:** Ali Layne-Smith	**Scrutinising Committee:** People and Culture
Date risk opened: 15/05/2019	**Date risk expected to be removed from the BAF: 30 September 2020**	
Change since last review:	Amendment of positive assurance of controls	

Underlying Cause/Source of Risk:	**Gross Rating**	**Current/Net Rating**	**Target Rating**
The Trust's ability to recruit and retain registered clinicians to our core front line operations (a sustainable workforce) will be affected by the changing landscape of the NHS (NHS Long Term Plan) which opens opportunities for paramedics to be employed in other healthcare setting and which will impact our ability to meet operational targets.	16	12	8

Existing Controls	**Positive Assurance of Controls**
1. The Trust has built strong pipelines for paramedic recruitment overseas which will allow it to respond to an under supply in the UK market 2. Strategic workforce planning has been developed over 2018/19 and has resulted in the establishment of a Strategic Workforce Planning Group which will be chaired by the Director of People and Culture and in which the Medical Director and Director of Operations will be essential participants. 3. Engagement in national workforce planning group to influence debate on challenges of English Ambulance Trusts with funded paramedic places 4. The Trust has an experienced recruitment team who have demonstrated their ability to flex to meet the recruitment targets required of the organisation and has recently moved it to HQ to give greater visibility of their work and to enable more collaborative and efficient ways of working with operational colleagues 5. The Trust is developing a paramedic apprenticeship to attract and retain local employee 6. The Trust is developing accessible career pathways for non-registered clinical roles 7. A training package has been developed that will support apprenticeships at L3 (Band 4 role); L4 (Band 5) role 8. A provider for an apprenticeship programme for paramedics has been chosen and agreement of the contract is pending. Following HCPC approval the course will commence in September 2020. All apprenticeship activities will then become business as usual.	1. International recruitment campaign is being planned for Summer / Autumn 2019 and 2020 2. Strategic Workforce Group re-launched October 2019 with revised longer term remit and membership. 3. Tender for paramedic apprenticeship is live and on track to meet deadline of December 2019 induction. 4. Skills Mix Matrix is the subject of ongoing executive meetings. Strategic Workforce Group will own this on behalf of ExCo

Further Actions	**Responsible Person/s**	**Due Date**
1. Determine skill mix to support patient requirements and operational delivery within the financial budget available. 2. Establish a skills mix that will meet the demand profile of the Trust with a realistic reliance on paramedic numbers	1. Directors - Medical, Operations, and People and Culture 2. Directors - Medical, Operations, and People and Culture	March 2020 March 2020

Signed: Ali Layne-Smith, Director of People and Culture

BAF Risk no. 58 There is a risk that the power management infrastructure at Bow and Waterloo is either not fit for purpose presenting a single point of failure, or old and requiring replacement. This may in the event of a power supply issue result in failure that will see disruption to EOC and frontline service delivery.				
Risk Classification: Strategic Assets and Property	**Risk Owner:** Khadir Meer	**Scrutinising Committee:** Logistics and Infrastructure Committee		
Date risk opened: 21/01/20	**Date risk expected to be removed from the BAF:** July 2020			
Change since last review:				
Underlying Cause/Source of Risk: Bow power outage following upgrade work, then a subsequent independent report commissioned for Bow and Waterloo by Mecserve.			**Gross Rating**	**Current/Net Rating**	**Target Rating**
			12	**12**	**2**

Existing Controls	**Positive Assurance of Controls**
1. Waterloo has a range of backup and ancillary arrangements on the site which whilst old, are working. UPS capacity is operating at 60% and the generator has been maintained regularly despite its age. 2. Bow has gone through a variety of upgrade works, however, is exposed to a particular kind of risk from the UK power network. This is a very rare event, considered to be 1 in 10 years. 3. The switch gear at Bow has been locked off into bypass mode with restricted access arrangements in place on site, limiting risk of electrocution to staff who are not professionally competent. **Gaps in Control** Bow: No isolation transformers on UPS system A single point of failure on the UPS system A manual (not automatic) switch on the UPS system. No wrap around bypass function on UPS system. No protection from a UK power network neutral surge event. There are no specific installation wiring diagrams for the installation. Waterloo: The generator is 30 year old and the supplier is unable to provide any documentation about its configuration, which would suggest obsolescence. No planned replacement programme in place for either generator or UPS equipment. UPS systems are not functioning as a 'parallel pair', with defective communications cards. The batteries are at the end of their intended lifespan, with deteriorating power capacity as a result. Limited parts holding via the manufacturer.	1. Commissioned independent reports for both sites. 2. Assurance has been received around aspects of the system that are working correctly. 3. Mecserve have been appointed as 'authorised engineers'. 4. Staging plan has been developed. 5. Working group including EOC and other key stakeholders has been established. 6. Key contractors to facilitate repairs have been appointed. 7. Parts required to effect repairs are on order. 8. Routine planned maintenance is ongoing. 9. Regular reporting and assurance is provided to meetings including the COO SMT, COO Quality Assurance and Compliance, RCAG, ExCo and LIC.

Further Actions	Responsible Person/s	Due Date
Waterloo 1. The provision of a fully functioning paralleled pair of UPS units with an onward design life of an acceptable period. 2. This solution will be the replacement of the two UPS units, batteries, etc. This would be operationally disruptive and would need careful consideration and planning. 3. A short term resilience improvement solution would be to take the UPS system off-line and install replacement communication cards and recommission the units as a parallel pair. 4. The standby generator will be replaced to provide a long term reliable standby power solution. 5. Replacement of all perishables is recommended Bow 1. Consideration will be given to incorporating isolating transformers into the UPS system. 2. The current manual switching between the two UPS input supplies is a single point of failure that will be overcome either by dual feeding the UPS system or replacing the manual switch with an automatic transfer switch. 3. Provide the UPS system with an overall wrap-around bypass facility. 4. The controls and signalling cabling will be replaced with screened and shielded cabling as per the Riello installation recommendations. 5. Riello will be tasked to provide “installation specific” schematic/wiring diagrams. 6. The maintenance bypass panel will be configured such that there are two output devices; one for each of the two outgoing supplies terminating into the downstream UPS output panel. 7. The UPS system will be re-commissioned from “first principles” and the critical power system will be fully “black building” tested for an appropriate period using a load bank at the capacity that the system is designed to support. 8. PowerPerfector and Riello will confirm that the 380volts output of the power conditioning unit is not to the detriment of the UPS system operational reliability (regarding switching to bypass). 9. The installer will provide a full set of recorded documentation in accordance with the Construction (Design and Management) Regulations 2015.		
Signed:		

Corporate (Trust Wide) Risk Register

ID	Sector / Department	Description	Opened	Rating (initial)	Risk level (initial)	Controls in place	Risk Owner	Last review date	Rating (current)	Risk level (current)	Assurance	Rating (Target)	Risk level (Target)	Progress Notes:
706	Estates	EOC Training have limitations on space and building facilities which may impact ability to deliver training and current lease is due to expire in December 2019 and new space has not yet been identified. There is a risk that insufficient capacity and or site conditions could cause interruption to Training courses and inability to deliver training on new systems including CAD and Pathways and additional stress to staff.	27/10/2017	25	High	Future space requirements are being considered as part of the Estates strategy. The current lease is being extended until December 2019 due to being unable to identify an appropriate alternative location and, also, due to the pressures on IM&T to support the move. IM&T also operate within the site and, again, would have required alternative space provision. A formal specification of EOC training requirements is to be created and alternative locations to be identified. To accommodate lead times for a relocation to new premises, a new location will need to be identified and agreed by August 2019.	Wand, Justin	09/01/2020	20	High	DDO Control Services is fully aware and briefed on the seriousness of the estate and impact on the training team. John Downard aware and supportive of the urgent review of premises and continued co-located situation.	8	Significant	09/01/20 Reviewed at 999 Operations Quality Group. Location secured at Barking from end of Jan. SBR extended to Dec 2020 with one month break clause. Agreed to reduce score to possible/major = 12. (to be approved by RCAG)
844	Fleet and Logistics	There is a risk of project slippage due to an undefined technical solution (Kit prep / Wifi) for medicines packing and management at Logistics Support Unit Deptford. This may lead to the maintenance of paper based systems and poor data collection if not properly managed.	01/10/2018	20	High	1. IM&T have attempted to put in a temporary solutions (ADSL) to support access to WIFI at Deptford. 2. Access to guest (LAS) WIFI is also available but this is time limited. 3. One BT and two IM&T engineers are exploring the issue to fix it.	Crichton, Stuart	29/11/2019	16	High	BT and two IM&T engineers provide status reports into the ongoing problem with suggested solutions.	4	Moderate	29/11/19 Reviewed at RCAG. Update on outcome of UAT testing so far added by JB to risk ID 945. To be completed 9-10 December.
872	HR / Workforce	There is a risk that the health and well-being of our staff may be compromised through the failure of our occupational health provider to meet the contract specification.	30/10/2018	12	Significant	1. PAM monthly performance review meetings with Account Manager (LAS representatives, Nicola Bullen and Julia Crossey, Sharon Edgell, H&S) 2. KPI Dashboard provided by PAM, monthly 3. Monthly CEO Performance meetings including progress update and on Imms progress 4. Formal letter to PAM setting out concerns of performance against contract 5. Monthly immunisation report provided by PAM to track progress 6. As needed meetings with recruitment as the major user of OH service	Layne-Smith, Ali	08/01/2020	16		Meeting with PAM Managing Director and Account Manager to escalate contract / service failures 2. Improvement Plan to be agreed and implemented. 3. KPIs to be reviewed at Contract Review Meeting to ensure they meet London Ambulance requirements. 4. Ready arrangements for alternative physio provision in the event of PAM service failure 5. Update ESR with IMMS for future holding of accurate data on Imms status 6. OH/Recruitment workshop to review / educate re OH service and expectations 7. Meeting with PAM Management team to track improvement plan	8	Significant	08/01/20 Reviewed at RCAG. Concerns raised through FTSU that iParas have not received the TB vaccine and recent incidents where crew refused to attend where patient had ?TB and also an iPara that was exposed to Hep B and HIV and had been missed for the Hep B booster a year previously and now having to take a course of PEP. Agreed for risk to be reworded to focus on immunisations as physio and counselling are in the main resolved. Risk will be escalated to QAC.
945	Medical Directorate	There is a risk to the integrity of the data being produced by Kitprep due to the system not working as expected which leads to inaccuracy in the Perfect Ward audit tool of expiry dates of drug packs and discrepancies when reconciling the number of drug packs with the system.	14/06/2019	15	High	Daily drug audit (Perfect Ward) Manual updates to system to rectify errors (incident reports submitted for all discrepancies and flagged to IM&T)	Fullerton, Ross	10/12/2019	15	High	Discussed at medicines management group bimonthly and included in the MSO report Reported at performance review	6	Moderate	10/12/19 Risk reviewed with DM Deputy Medical Director and VW BSM to Medical Director. Awaiting outcome of UAT and potential go live next week.

967	Organisational Development	There is a risk that patient experience will be adversly impacted at specific times of the week as a result of the lack of flexibility within the current Annual Leave agreement in place within operations resulting in a significant drop in the number of available staff and longer patient waiting times for category 2/3 calls.	30/07/2019	20	High	Use of supplementary roster to aim to provide additional staffing Use of overtime OPC rostering with high focus on weekend provision PAS/VAS commission	Layne-Smith, Ali	08/01/2020	16	High	Performance data	8	Significant	08/01/20 Reviewed at RCAG. National guidance for safe staffing has been issued. Will form part of the exec discussions.
973	Strategic Assets and Property	There is a risk that ambulance premises, operational ambulance fleet HQ, vehicle security and other LAS assets may be accessed by unauthorised persons because of inadequate physical security arrangements, which may lead to damage and/or loss of assets which are critical for the delivery of the care and patient safety patients, unplanned financial costs for the repair/replacement and damage the reputation of the Trust if not properly managed.	02/09/2019	15	High	1.Security Management Policy implemented. 2.Organisational procedure on station duties in place and communicated to staff. 3.Incident reporting system in place to enable the prompt reporting, investigation and management of incidents. 4.Security surveys being carried out on vulnerable sites. 5.Support available from the Metropolitan Police where acts of theft, damage, vandalism are reported. 6.Security awareness training incorporated into H&S training delivered across the Trust. 7.Engagement of security guards at sites where delays in garage door/shutter repairs are outstanding	Justin Wand	08/01/2020	15	High	Incidents reported on Datix. 2. Monitoring of Incident reports by Corporate Health & Safety Committee. 3. Regular review of incidents by Trust LSMS.	4	Moderate	08/01/20 Reviewed at RCAG. Due to CQC report agreed to increase score back to Possible/Catastrophic = 15. Agreed to amend wording to include HQ and vehicle security.

London Ambulance Service NHS Trust

Report to:	**Trust Board**			
Date of meeting:	28 January 2020			
Report title:	Serious Incident Update			
Agenda item:	12			
Report Author(s):	Helen Woolford, Head of Quality Improvement and Learning			
Presented by:	Dr Trisha Bain, Chief Quality Officer			
History:	N/A			
Status:	☒	**Assurance**	☐	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

This paper includes an overview of incident and serious incidents (SI) reported and declared in December 2019.

The Trust continues to see good reporting of patient safety incidents resulting in 3.7 events per 1000 incidents with increases in no and low harm incidents being reporting, which is positive. This allows the Trust to identify themes.

Medical equipment, dispatch and call management and clinical treatment issues remain the recurring themes albeit low numbers proportionally to the overall call volume.

There were 17 SIs declared in December whereby high demand, delays in call and dispatch have been identified as a patient safety theme and the Chief Medical Officer is maintaining daily oversight of delays to assess any potential harm.

Recommendation(s):

The Trust Board is asked to note the contents of the report.

Links to Board Assurance Framework (BAF) and key risks:

N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:

Clinical and Quality	☒
Performance	☐
Financial	☐
Workforce	☐
Governance and Well-led	☒
Reputation	☒
Other	☐

This report supports the achievement of the following Business Plan Workstreams:

Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☐
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☐

London Ambulance Service –Serious Incident/Incidents Monthly Report

Report for discussion at the Trust Board

Analysis based on December 2019 data, unless otherwise stated

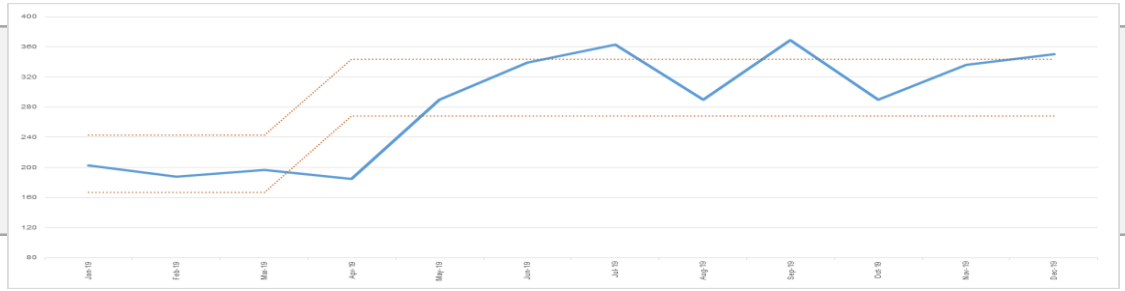
Patient Safety

The total number of adverse patient events was 408 resulting in 3.7 events per 1000 incidents. The breakdown of these events is shown in the analysis below:

No Harm/Near Miss

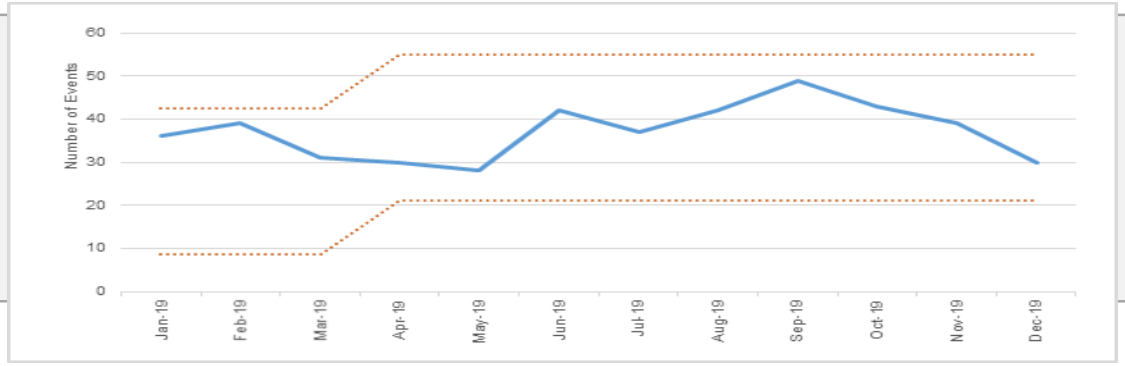
Latest Month: **350**

Monthly Trend



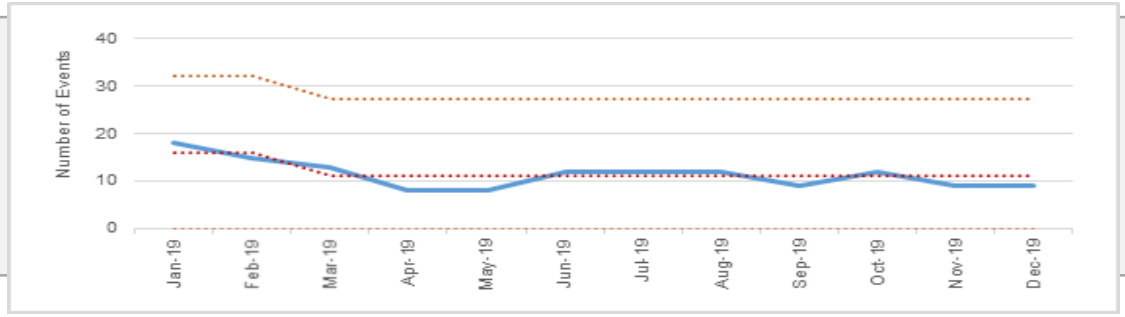
Low Harm

Latest Month: **30**



Moderate Harm

Latest Month: **9**



The Governance Department continues to encourage the reporting of all incidents.

The SPC charts have been updated and show a step change due to the increase in no/low harm incidents being reported.

Analysis indicates that we are likely to continue to see an increase in no harm and near miss incidents being reported, which is positive/

The SPC chart has been updated and shows that moderate harm incidents has slightly decreased. Analysis suggest that this is due to better understanding of harm levels and stronger scrutiny by the QGAMs and central governance team of these incidents.

Data Source:

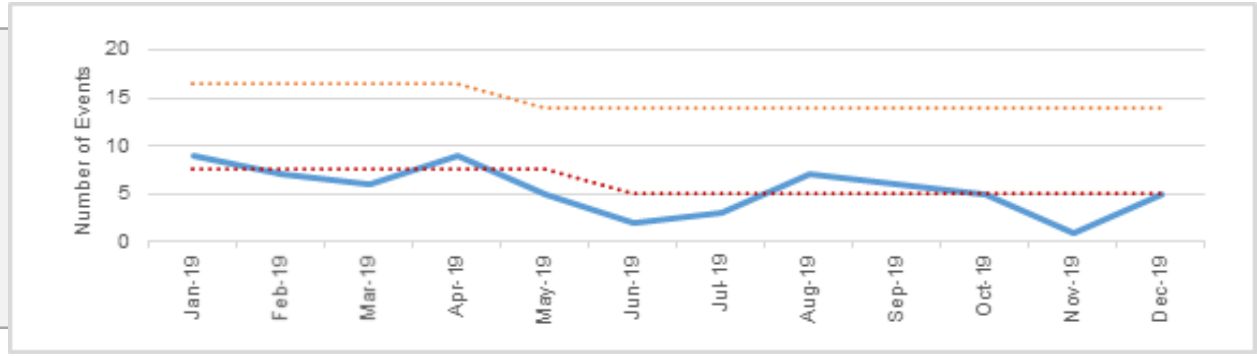
CHART KEY
- Monthly value
- Target
- Mean (Baseline FY17/18)
- Upper and Lower Limit (Baseline FY17/18)

Patient Safety

Monthly Trend

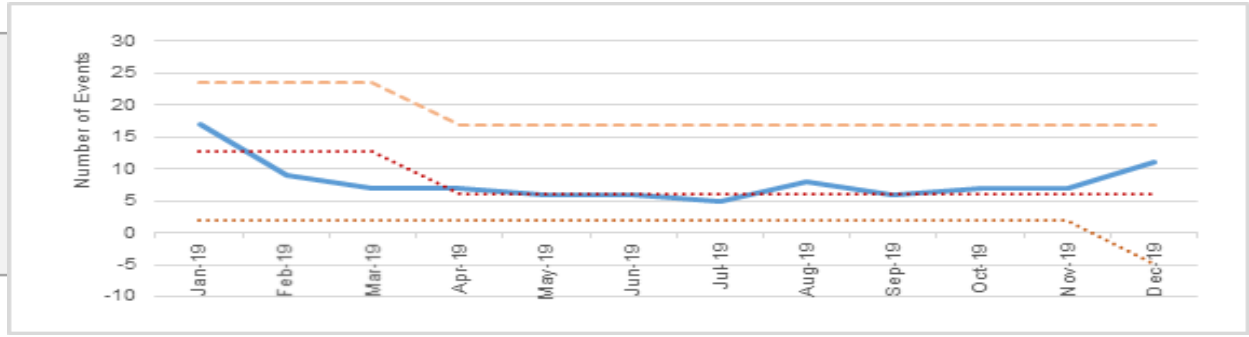
Severe

Latest Month: 5



Death

Latest Month: 11



The SPC charts for severe and death incidents have been updated and show a decrease in these incidents.

Analysis suggest that this is also due to better understanding of harm levels and stronger scrutiny by QGAMs and the central governance team.

Data Source:

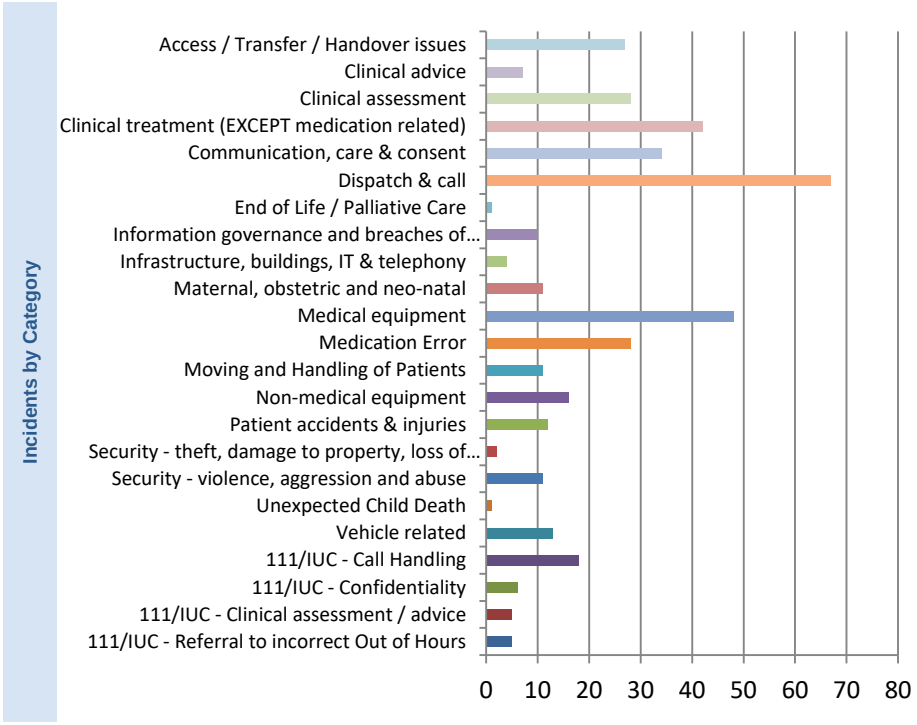
CHART KEY
- Monthly value
- Target
- Mean (Baseline FY17/18)
- Upper and Lower Limit (Baseline FY17/18)

Below are our incident themes, action being taken to address them and how we share the learning from these across the Trust.

Incident Themes

Medical Equipment, dispatch and call management and clinical treatment issues remain the recurring themes albeit low numbers proportionally to the overall call volume.
Actions are being taken to address these themes including:

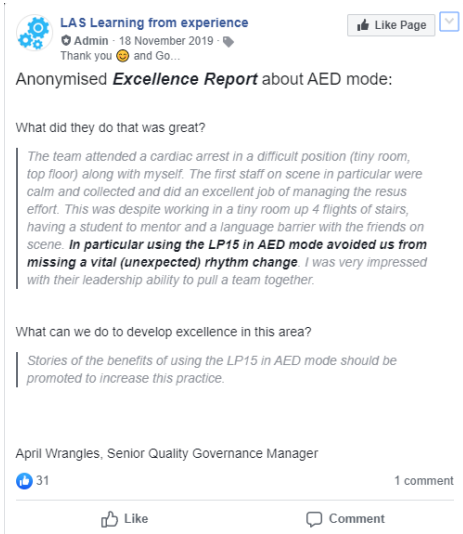
- Information being circulated regarding the faulty equipment process for timely repair of equipment.
- Call and dispatch incidents are being reviewed daily and the Chief Medical Officer is maintaining daily oversight of delays to assess any potential harm.



Learning

Listening into Action – The team have used an internal closed social media platform to promote key learning messages from incidents.

This has included; delayed defibrillation, management of hypothermic cardiac arrests and staff roles and responsibilities when commencing duty. These post have been well received and generated positive discussion.
A sample of some of these posts are below:


LAS Learning from experience
Admin · 18 November 2019 ·
Thank you and Go...
Like Page

Anonymised ***Excellence Report*** about AED mode:

What did they do that was great?

The team attended a cardiac arrest in a difficult position (tiny room, top floor) along with myself. The first staff on scene in particular were calm and collected and did an excellent job of managing the resus effort. This was despite working in a tiny room up 4 flights of stairs, having a student to mentor and a language barrier with the friends on scene. ***In particular using the LP15 in AED mode avoided us from missing a vital (unexpected) rhythm change****. I was very impressed with their leadership ability to pull a team together.*

What can we do to develop excellence in this area?

Stories of the benefits of using the LP15 in AED mode should be promoted to increase this practice.

April Wrangles, Senior Quality Governance Manager

31 1 comment

Like Comment


LAS Learning from experience
Admin · 18 November 2019 · Clinical discussion
Like Page

Cold Weather Alert

As the weather starts to get colder please remember the specific guidelines in relation to hypothermic patients

RISK FACTORS FOR HYPOTHERMIA:

- Older patients > 80 years
- Children
- Some medical conditions (hypothyroidism, stroke etc)
- Intoxicated patients
- Immobility and injury
- Decreased level of consciousness
- In association with drowning and in patients exposed to cold, wet and windy environments especially is inadequately dressed

As the core body temperature falls there may be the development of cardiac arrhythmias, such as sinus bradycardia, AF, VF and asystole.

Attending a cardiac arrest, for most, is a rare event. Attending a cardiac arrest where the patient is hypothermic is even rarer.

Last winter 4 cases were reported where a patient in cardiac arrest received the incorrect cardiac arrest management

REMEMBER:

✔For hypothermic patients with a tympanic temperature less than 30, no drugs should be administered (regardless of the cause of the arrest).

✔On the rare occasion where hypothermia is believed to be the cause of the cardiac arrest and the patient presents in a shockable rhythm, 3 shocks should be delivered while on scene and the patient removed to the vehicle and transported. Shocks may be continued en route to hospital as appropriate.

For more information please check out your ✅ ***JRCALC + app*** or refer to ✅ ***Cardiac Care Circular 007***

April Wrangles, Senior Quality Governance Manager

58 2 comments

Like Comment

We must ensure we report, track and respond to serious incidents appropriately – the below analysis highlights the current trends around where our serious incidents are being reported, the current status of our response and where we still have outstanding actions to address as a Trust.

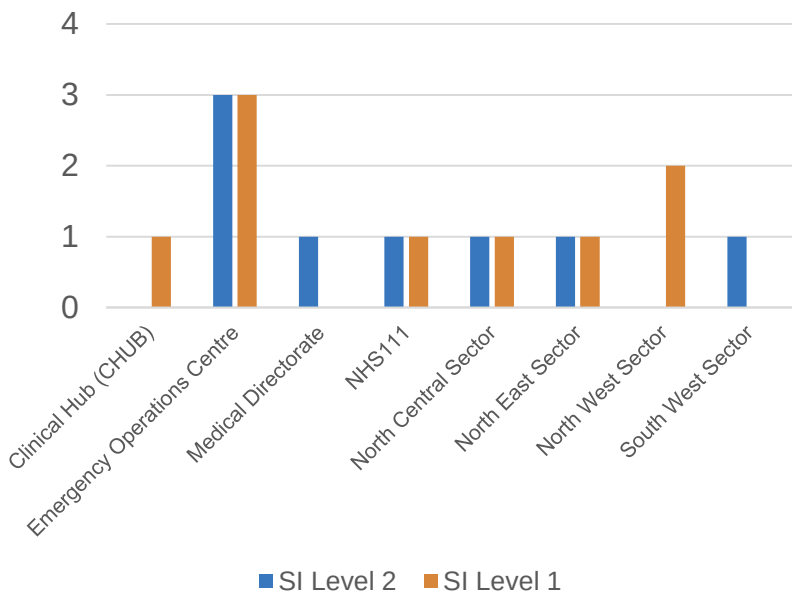
Serious Incidents

During December 2019, 17 reported incidents were declared as SIs after review at the Serious Incident Group (SIG). Fig. 1 shows the monthly distribution of declared SIs across the Trust.

Due to recent high demand, delays in call and dispatch has been identified as a patient safety theme and the Chief Medical Officer is maintaining daily oversight of delays to assess any potential harm.

Delayed Defibrillation Thematic Analysis – A second thematic analysis of delayed defibrillation was completed at the beginning of November. The action plan is being monitored through SIALG. There have been no recent delayed defibrillation SIs declared in recent months.

Monthly Analysis



Learning from Serious Incidents

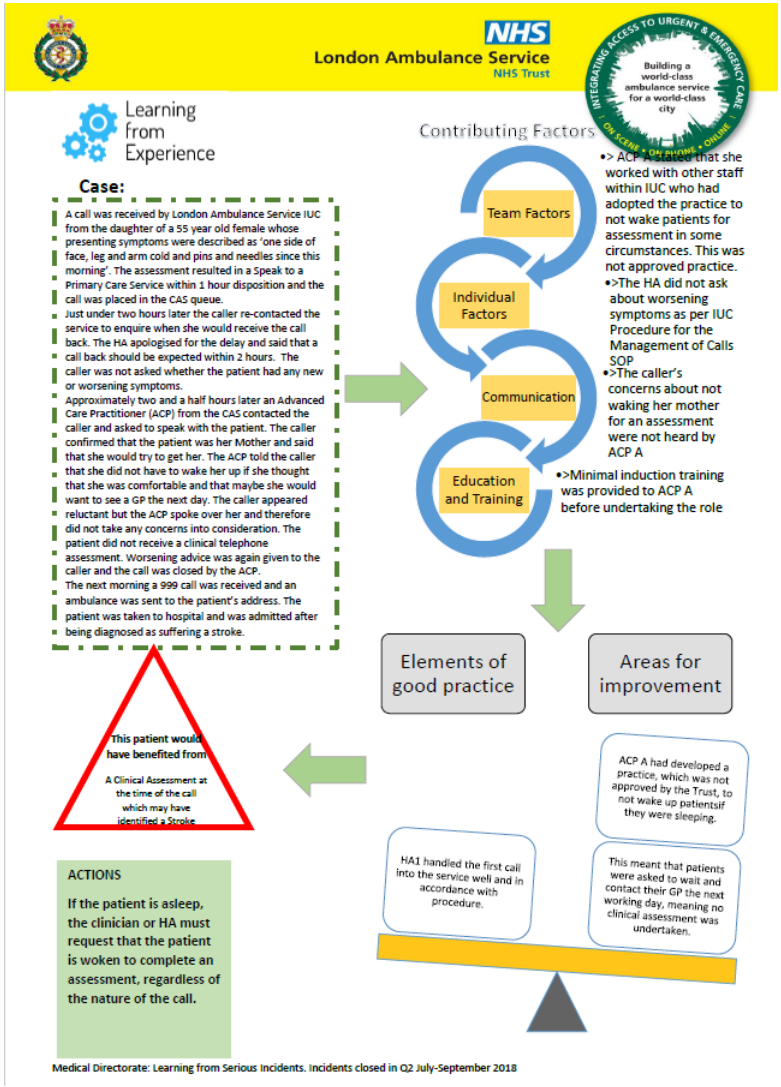
Insight magazine – The latest edition of INSIGHT magazine was released in November and included some of the learning found during Serious Incident investigations.

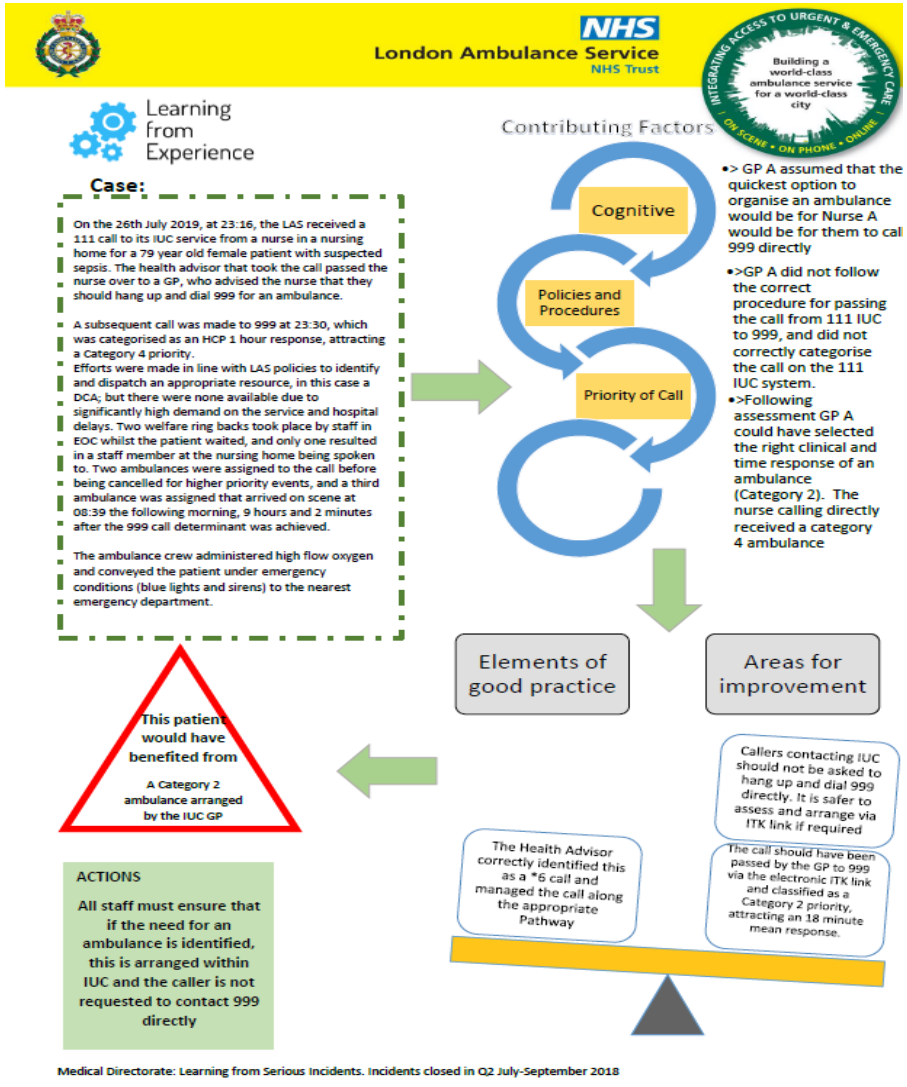
Topics covered included the recognition of ineffective breathing by Emergency Call Handlers, the importance of using decision making tools such as the falls decision tree; documentation of difficult conversations with patients and relatives when discussing non-conveyance and the associated risk factors; and the effect of confirmation bias during telephone triage in the IUC services.

Serious Incident Case Review Evening – This event took place at the end of November and staff from across the Trust were invited to attend and partake.
A total of 5 serious incidents were presented by their respective lead investigators who highlighted the key learning points for each case.

Topics included the confirmation bias associated with attending patients presenting with chest pain; the recognition of sepsis during telephone triage; mapping software issues; information governance breeches in the form of missing patient report forms; and delayed defibrillation.
The event was well attended and will run quarterly.

At the conclusion of incidents, a learning from experience infographic is distributed across both IUC services and EOC if applicable. 2 recent releases below





London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	28 January 2020			
Report title:	Care Quality Commission (CQC) report			
Agenda item:	13			
Report Author(s):	Care Quality Commission (CQC)			
Presented by:	Dr Trisha Bain, Chief Quality Officer			
History:	N/A			
Status:	☒	**Assurance**	☐	**Discussion**
	☐	**Decision**	☐	**Information**

Background / Purpose:

The attached Care Quality Commission (CQC) Report shows the outcome of the inspection undertaken by the CQC during 2019. The Trust have maintained an overall rating of 'good' , with a 'requires improvement' rating under the Safe domain within Emergency Operations Centre (EOC) and Emergency services, the Caring domain moved from outstanding to good. The CQC requested that the Trust 'Must' take action in two regulatory domains:

Regulation 17: Good Governance (within our Integrated Urgent Care (IUC) services)

- Monitor the quality of GP decision making in relation to the prescribing of medication
- Review the process in place for monitoring the call quality of operational staff.
- Review the process in place for disseminating information to staff

Regulation 12: Safe Care and treatment (within Emergency Care services)

- Ensure that medicines are correctly stored, identifiable and batch numbers and expiry dates are clearly visible.
- Ensure that the arrangements to secure vehicles and equipment are improved.

Action plans relating to the two 'must dos' have been developed and the response provided to the CQC on 16 January 2020 is attached to this report. These regulatory action plans will be monitored weekly via the Chief Operating Officer (COO) senior management meetings and reports will be provided to Quality Oversight Group (QOG), Quality Assurance Committee (QAC) and the Board on a monthly basis.

Improvement plans that include the 16 'should dos' are in development for all relevant services, these will be reported to the QOG, QAC and Board via inclusion within the quality report. A review of all business plans and the annual quality account priorities will be undertaken to ensure that additional quality objectives that aim to further improve the current quality standards rating will be undertaken. Once finalised and agreed by all directors, these will be reported and monitored via the quality governance reporting framework and to the Board.

Recommendation(s):
The Board is asked to review the report and agree actions.
Links to Board Assurance Framework (BAF) and key risks:
N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☒
Financial	☒
Workforce	☒
Governance and Well-led	☒
Reputation	☒
Other	☐
This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☐
Partners are supported to deliver change in London	☐
Efficiency and sustainability will drive us	☐

Report on actions you plan to take to meet Health and Social Care Act 2008, its associated regulations, or any other relevant legislation.

Please see the covering letter for the date by when you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RRU
Our reference	INS2-7351152261
Location name	London Ambulance Service NHS Trust

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 12** **Safe care and treatment**
	How the regulation was not being met:
	The trust must ensure medicines are correctly stored, identifiable and batch numbers and expiry dates are clearly visible.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1. *The trust must ensure medicines are correctly stored, identifiable and batch numbers and expiry dates are clearly visible.*

We will continue with the roll out of the Secure Drugs Rooms project, with a view to completing phase 2 (further 17 sites) by 31st July 2020. For remaining sites we will scope for the inclusion of temperature monitoring, this will be included in the business plan for 2020/21. The aim for completion will be 31st March 2021. We have reviewed the temperature control procedure and will approve at the next medicines management group (4th February 2020).

We will continue with the multi-dose bag project roll out, and aim to test proof of concept in June 2020. If successful, we will roll out Trust-wide in September 2020. Upon completion, the multi-dose bag will ensure that all station based drugs are stored in a pouch system; thus ensuring all medicines in the LAS are in a labelled pouch with batch number and expiry date visible. This is will reduce the risk of drugs being stored in vehicles and will ensure that all medicines are tracked in and out of secure drugs rooms.

All drugs will continue to be scanned onto the KitPrep track and trace system, which is being further developed to include scanning at point of care. This will facilitate the multi-dose bag project.

A bulletin has been cascaded to remind staff to check the batch number and expiry date on all medicines and to ensure that medicines, such as salbutamol nebules, have the expiry date reduced once the foil wrapping is opened and remaining nebules are protected from UV light – in accordance with the manufacturer's instructions. The removal of personal issue paramedic bags as part of the Primary Response Bags project will assist with tighter management of loose drugs.

The Medicines Management Team will be delivering a CPD event on 5th March 2020 for all managers.

Who is responsible for the action?	Director for Strategic Assets and Property. Chief Pharmacist Trust Medication Safety Officer

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

1. *The trust must ensure medicines are correctly stored, identifiable and batch numbers and expiry dates are clearly visible.*

Quality assurance check list completion for phase 2 of secure drugs rooms. Continuation of Perfect Ward daily audits, with reporting to the Medication Safety Officer and Medicines Management Group. Review of Perfect Ward Audit data to ensure that outstanding compliance is achieved and maintained with support given to sites that may require further guidance.

Case studies and staff feedback post CPD event. Medicines Management Team to continue to conduct pharmacist-led Trust wide audits, which uses the overall indicators from the Safe and Secure Handling of Medicines Guidance (September 2018).

Who is responsible?	Director for Strategic Assets and Property. Chief Pharmacist Trust Medication Safety Officer

What resources (if any) are needed to implement the change(s) and are these resources available?

1. *The trust must ensure medicines are correctly stored, identifiable and batch numbers and expiry dates are clearly visible.*

The Secure Drugs Rooms project will require funding and project management for the continuation of phase 2 and for the ongoing maintenance costs for the rooms and equipment. The finances, project manager and project team are established.

The multi-dose bags project will require funding and project management for phase 2 of Kitprep and for the ongoing costs for bags and medicines. The finances, project manager and project team are established. We also have confirmation from Perfect Ward that the developer has been recruited to continue with KitPrep phase 2.

The Chief Medical Officer has confirmed funding and support for the CPD event on 5th March 2020.	
Date actions will be completed:	Secure Drugs Rooms – funding and project management complete – 31st July 2020 Multi-dose bags - funding and project management complete – 30th September 2020. CPD event – 29th February 2020.

How will people who use the service(s) be affected by you not meeting this regulation until this date?

1. *The trust must ensure medicines are correctly stored, identifiable and batch numbers and expiry dates are clearly visible.*

Patients and the public will be assured by the ongoing outstanding treatment that we will provide. Our policies and procedures are clear with regards to the checking of batch number and expiry dates for drugs, cross-checking prior to drug administration and the use of the KitPrep system. We continue to conduct Trust-wide medicines management daily audits to mitigate any risks. Also staff continue to report incidents via Datix, these are collated and reported bi-monthly to the Medicines Management Group.

Completed by: (please print name(s) in full)	Sumithra Maheswaran
Position(s):	Chief Pharmacist
Date:	13th January 2020

Report on actions you plan to take to meet Health and Social Care Act 2008, its associated regulations, or any other relevant legislation.

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Location name	London Ambulance Service NHS Trust

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 12** **Safe care and treatment**
	How the regulation was not being met:
	• *The trust must ensure the arrangements to secure vehicles and equipment are improved.*

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

Driver Safety, Asset Management & Security System

The Trust has approved a business case to pilot the installation of a Driver Safety, Asset Management and Security system into 36 new vehicles. This system will include 'Black Box' recording, Radiofrequency Identification (RFID), CCTV and sensor based technologies. These vehicles are expected to join our fleet in Q4 2019/20 with deployment planned for early Q1 2020/21. This pilot will provide the basis for configuration adjustments before further roll out later this financial year. Completion of this project is likely to take 3 years to complete across the fleet.

The tracking of vehicles, medicines and equipment will be subject of the Driver Safety, Asset Management and Security system. This system will see the use of RFID to track key items of medical equipment, drugs pouches and response bags. Staff at our Logistics department will have access to a packing app that provides an additional layer of governance and allows for real-time audit of drug usage, batch numbers and expiry dates. In preparation for this, vehicle based Advanced Life Support, Primary response bags and multi-dose drug packs will be tagged ahead of the go-live date.

Multidose drugs pack rollout will commence during Q1 2020/21 after the further development of kit prep app to include a packing app (used by logistics support teams), amber tag and clinical usage forms. Trust wide roll out will be completed Q3.

Make Ready

Our Make Ready tender is currently being prepared for market testing, Make Ready teams ensure vehicles are prepared, cleaned, re-stocked and all equipment is present and working

before use. This new tender will see the range of vehicles supported increase to include Fast Response Unit cars and Non-Emergency Transport Service vehicles, extended hours of operation (24/7) and more robust support for staff. The make ready process will capture data electronically at the point of inspection and record this centrally. This will enable us to identify trends and shortfalls and make adjustments in a continual programme of improvement.

Ambulance Station & Vehicle Security and Estates Rationalisation

The Trust is fully committed to ensure the safety and security of our people and property and is driving a cultural change with staff of all grades that reflects the need to protect against the world we live from opportunistic theft and those who may have a more sinister intent. All local managers were called to a meeting with members of the Trust's Executive team who shared the efforts being taken to improve security across the organisation but also where it was explained that a zero tolerance stance was to be taken in response to all avoidable breaches in security whether through negligence or carelessness.

With the support of our Internal Communications team we introduced the 'It's ok to challenge' campaign aimed at empowering staff to challenge anyone who is not displaying their ID card and to speak up if they have any concerns. We produced posters with a 'Shut it, Lock it, Report it' slogan that reinforces the message that all stations must be secured at all times including windows and that doors should not be propped open. That vehicles are locked when not in use and the keys stored in the key safe and that all breaches are reported.

Following a Trust-wide audit in 2019, it was identified that a number of our ambulance stations had issues with security that required the immediate deployment of security personnel to the site until such time as a permanent solution could be found. A rapid programme of repair and replacement of a number of station security features was implemented and overseen by the Chief Executive Officer, Director of Operations and Director of Strategic Assets and Property. This has now been completed however at one station a security guard remains in place as the already replaced shutters require further works.

The Trust is developing an Estates Rationalisation strategy that will enable us to streamline resources and provide an enhanced service that not only offers better value for money but enables an improved level of oversight and governance. In the meantime, we have secured a new contractor with the resources available to respond to security issues in a timely manner and with the means to undertake works on a mature estate.

Fleet Reconfiguration

Whilst our vehicles are off-site and responding to patients, it is often the case where staff are required to attend to the patient as a priority as dictated by their condition. Our ambulance fleet was previously designed in such a way that reduces the steps needed to load or off-load a patient and equipment by utilising the tail-lift as a rear door when stowed. This also reduced the weight of the vehicle. The disadvantage of this is that when the tail-lift is deployed the vehicle cannot be secured unless it is re-stowed which may delay patients receiving the care they need in life-threatening situations. As a result, our ambulance fleet has been redesigned to include a supplementary door that can be closed when the tail lift is deployed with no impact on patient care and are phasing out the older type. To date we have replaced 160 out of 450 ambulances with the new type door and are expecting 91 others to be delivered by the end of the financial year. The remaining vehicles will be replaced as part of an ongoing replacement programme to

be delivered across the next 3 years.

Mystery Shopper Audits, Quality Visits and Station Spot Checks

The Trust has introduced a programme of randomised inspection and audit of all sites along with further improving those already in place such as Health and Safety risk assessments. The Health, Safety & Security department are charged with undertaking cyclical 'Mystery Shopper' audits of operational sites. This includes (amongst many different criteria) a review of perimeter security, access control and vehicle security both within and around the station boundary. In Q4 2019/20 all stations will be inspected every month and a report prepared for the Quality Assurance Committee. In addition, the Operational Compliance & Standards department are supporting the Mystery Shopper audits with randomised station spot checks. All identified breaches through either inspection mechanism are reported on the Trust incident reporting system and are investigated by a senior manager.

The Quality Directorate also undertake Quality Visits of all Trust Operational sites at least once per year. These mirror CQC inspections and form part of the assurance process that our sites are Safe, Responsive, Effective, Caring and Well Led. Visits are tailored to previous feedback from both internal and external partners. Staff also have the opportunity to speak to the visiting team openly about incident reporting and how they see their part in working for the LAS contributing toward delivering a world-class service. Where issues are identified the frequency of quality visits, audits and spot checks is increased until such time a measured improvement is observed.

Data from these inspections has been used to develop action plans written and owned by senior operational managers and the Head of Estates.

Who is responsible for the action?	**Driver Safety, Asset Management & Security System, Make Ready Tender, Estates rationalisation and Fleet reconfiguration** - Interim Director of Strategic Assets & Property **Mystery Shopper Audits** - Head of Health, Safety & Security **Quality Visits -** Head of Quality Improvement & Learning **Station Spot Checks** – Senior Operational Compliance Support Manager

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

- Through a programme of continuous audit and improvement. Audit and compliance data will be analysed and reported through a Trust Board sub-committee. Clearly articulated S.M.A.R.T actions will be developed where areas of improvement are identified.

- Incident report surveillance in order to identify emerging themes and risks will be escalated through the Quality Report and Serious Incident Learning and Action Group.

- New initiatives such as the Driver Safety, Asset Management and Security System are pioneering in the Ambulance service and will be overseen through the Projects & Programmes directorate who report progress to the Chief Operating Officer.

Who is responsible?	**Audits** – Head of Health, Safety & Security **Incident Surveillance** – Head of Quality Improvement & Learning **Driver Safety, Asset Management and Security System** – Interim Director of Strategic Assets & Property and Director of Projects & Programmes.

What resources (if any) are needed to implement the change(s) and are these resources available?

Significant financial investment is required for the delivery of the Driver Safety, Asset Management and Security System. The business case has been approved for an initial pilot of the system with further funding required should the project progress to the rest of the fleet. Capital funding has been identified and allocated to the pilot. Additional funding for the remaining fleet will be decided at a later date pending a review of the initial pilot. The Trust has employed a temporary member of staff with previous expertise in the development of such systems and is providing project support.

ALS vehicle based bag rollout has been completed. Primary Response bags procured and nearing rollout completion.

Fleet reconfiguration is part of an ongoing programme of replacing older vehicles with newer, more eco-friendly ones that our crews are able to secure in all circumstances.

Date actions will be completed:	**Driver Safety, Asset Management and Security Systems** – These vehicles are expected to join our fleet in Q4 2019/20 with deployment planned for early Q1 2020/21 **ALS –** Completed **Primary Response bags –** Completion by end of February 2020 **Multidose drug bags –** Completion by end of Q3 2020/21 **Fleet reconfiguration –** Current order due for rollout by March 2020 **Mystery Shopper Audits** - Ongoing

How will people who use the service(s) be affected by you not meeting this regulation until this date?

There is a small risk of medicines that have passed their expiry date being in circulation on frontline vehicles however the risk of these being administered to patients is negligible due to the processes in place requiring staff to cross-check all medicines before administration to a patient. Our staff have been reminded to check medicine expiry dates for vehicle based medicines and have been instructed to remove any found to be out of date during the vehicle daily inspection process reducing this risk even further. As noted in the inspection report, safety incidents are managed well and staff understand their responsibilities with regards to

incident reporting. We continue to monitor incident reports centrally and at a local level and will immediately take steps to mitigate against any emerging themes including medicines management.

Completed by: (please print name(s) in full)	Michael Ward
Position(s):	Senior Operational Compliance Support Manager
Date:	14th January 2020

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Account number	RRU
Our reference	INS2-7351152261
Location name	London Ambulance Service NHS Trust

Regulated activity	**Regulation**
Treatment of disease, disorder or injury	**Regulation 12** **Safe care and treatment**
	How the regulation was not being met:
	The trust must ensure medicines are correctly stored, identifiable and batch numbers and *expiry dates are clearly visible.* *• The trust must ensure the arrangements to secure vehicles and equipment are improved.*

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
Who is responsible for the action?	
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
Who is responsible?	
What resources (if any) are needed to implement the change(s) and are these resources available?	

Date actions will be completed:	

How will people who use the service(s) be affected by you not meeting this regulation until this date?

Completed by: (please print name(s) in full)	
Position(s):	
Date:	

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 17** **Good governance**
	How the regulation was not being met:
	Monitor the quality of GP decision making in relation to the prescribing of medication. *• Review the process in place for monitoring the call quality of operational staff.* *• Review the process in place for disseminating information to staff.*

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

Who is responsible for the action?	

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

Who is responsible?	

What resources (if any) are needed to implement the change(s) and are these resources available?

Date actions will be completed:	

How will people who use the service(s) be affected by you not meeting this regulation until this date?

Completed by: (please print name(s) in full)	
Position(s):	
Date:	

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Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1. *Monitor the quality of GP decision making in relation to the prescribing of medication.*

   We will continue to review ePACT2 prescribing data with the CCG pharmacy leads and investigate any outliers on a case by case basis. In November 2019 we initiated a routine prescribing audit plan and we will review prescribing on a monthly basis for antimicrobials, repeat prescribing, opiates and drugs of abuse potential. Data has been regularly analysed by the medicines management team to ensure that we adhere to local and national prescribing formularies since the start of the IUC CAS. Also we will continue with the regular monthly Adastra audits of prescribing clinicians. Clinical audit information will continue to feed into regular 1:1 meetings and area Commissioner Quality meetings.

   We currently present and review prescribing data at the LAS IUC prescribing committee, which reports to the Medicines Management Committee as a standing agenda item. Also reporting and analysis will continue at the area prescribing committee meetings.

   Our prescribing policies and procedures are regularly reviewed to ensure that we are aligned and adaptable to the local and national protocols.

2. *Review the process in place for monitoring the call quality of operational staff.*

   In order to monitor call quality in the IUC CAS, we currently carry out call audits on a minimum of 3 cases a month for each operational staff member. We are in the process of reviewing the audit tool used and the audit criteria with the aim of implementing a more efficient way of carrying out call audit, with automated reporting and regular dissemination

of audit feedback.

All staff with less than or equal to three months' service receive five random quality audits per month. After demonstration of satisfactory practice audits are reduced to a standard of three per month. Audit scores are structured into timeframes to received feedback, which could be immediately, before commencement of next shift or routinely at 1:1 meetings with managers.

The Governance and Assurance Teams report monthly on the themes arising from audit and detail Quality Improvement initiatives put into place to address themes found.

End to End audits are held monthly, focusing on a particular topic each month and are completed with external stakeholders in order to allow a wider systems approach to improving quality.

Audit levelling workshops are in place to ensure that auditors are benchmarked against agreed standards to encourage consistency across quality monitoring.

3. *Review the process in place for disseminating information to staff*

   It is important that a variety of methods are used to disseminate information to staff. We will continue to use staff bulletins and email; however we will also continue to provide key information in hard copy that staff are required to sign out, and to utilise noticeboards to ensure that information is visible throughout the call centre. We will further utilise LAS publications such as the RIB, Insight and Clinical Update, as well as our intranet page on the Pulse. We will also invest in screens for the call centres where up-to-date information and reminders can be displayed to staff in real time. We will refresh the clinical desktop buttons in North East London and implement them in South East London. We will also continue to use team huddles and quarterly CPD events. The CPD events will be recorded and uploaded onto the intranet so staff who are unable to attend can benefit from the training.

Who is responsible for the action?	1. GP clinical leads and IUC lead pharmacist 2. CAS Manager 3. Operational Site Managers and Clinical managers

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

Audit numbers and themes will continue to be monitored through the monthly quality reports produced by the governance team.

Quarterly targeted audits on prescribing will also be reported in the quality report as well as at the internal prescribing meetings feeding into the LAS medicines management group. Feedback will be given to clinicians and recorded in their personal files. Improvements will be tracked.

In terms of information dissemination, by using a multifaceted approach we will see improvements in access to information. Staff will feel better informed and empowered to carry out their work effectively. Staff will know where to find information where required. This will lead to better adherence to policies and procedures.

Who is responsible?	1. Head of IUC Clinical 2. Head of IUC Delivery 3. QGAM

What resources (if any) are needed to implement the change(s) and are these resources available?
Audit tools – currently we utilise spreadsheets to carry out audit at both sites, however there is the option of using the embedded Adastra Quality Assurance Manager tool or MyAssure. An options appraisal is underway. However the current spreadsheet method is fit for purpose and can achieve the required outcome. A dedicated audit administrator to collate results of all audits for individuals in order to establish performance trends and ensure the required volume of audits is consistently achieved. Prescribing audit – this can be achieved utilising current processes. Dissemination of information – additional screens required in NEL and SEL call centres, desktop buttons to be implemented in SEL; all other methods of communication are currently taking place and no additional resources are required.

Date actions will be completed:	31 March 2020

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Minimal impact as actions are enhancing current processes to ensure we continue to strive for an outstanding service for our service users.

Completed by: (please print name(s) in full)	Athar Khan
Position(s):	Director of Integrated Patient Care
Date:	14 January 2020

CQC HSCA Compliance
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA
Telephone: 03000 616161
Fax: 03000 616171
www.cqc.org.uk

Garrett Emmerson
London Ambulance Service NHS Trust
220 Waterloo Road
London
SE1 8SD

3 January 2020

Your account number: RRU
Our reference: INS2-7351152261

Care Quality Commission
Health and Social Care Act 2008
Inspection report and report on the action you plan to take

Organisaton name: London Ambulance Service NHS Trust
Organisation ID: RRU

Dear Mr Emmerson

Following our recent inspection of London Ambulance Service NHS Trust, we have enclosed a copy of our report of the findings. Please make this report readily available for people who use the service.

We reviewed your comments relating to any factual inaccuracies in the draft report and have made change(s) in the enclosed report.

The changes made as a result of your comments relating to factual accuracy did impact on the ratings contained within the final report as follows: overall effective was changed from ‘requires improvement’ to ‘good’.

When we have published this report you can see the contents and download a PDF version by clicking on this link.

www.cqc.org.uk/directory/RRU

Once published, you can see this at any time by following these steps:

- Go to the CQC website www.cqc.org.uk.
- Click the appropriate tab for your type of service.
- Type in the name of your trust or hospital – if it appears automatically, click on it to jump to your profile page or click the 'search' button.

- Click on your trust your report will be on your profile page.

Challenging the rating(s)

A rating review involves checking whether or not CQC followed its process for making ratings decisions, as explained in the guidance published on our website. If you think that we have not followed the process you can request a review. You cannot ask for a review of ratings on the basis that you disagree with our judgements.

You must submit your request for review, using the online form, within 15 working days of the publication of your report(s). You must say in what way we have not followed the process, and which ratings you think have been affected.

Please use the following link to access the form:
http://www.cqc.org.uk/content/requesting-review-one-or-more-cqc-ratings

Please note that a rating review does not involve a reconsideration of the evidence and ratings awarded, unless we find the process has not been followed.

You can only request a review of ratings once after each inspection. Please note that requests for reviews of ratings can lead to ratings going down as well as up, or they can remain the same.

Post-Inspection Survey

Around 4-12 weeks after you have received your final inspection report CQC will email an invitation to take part in our Post-Inspection Survey**.** The email will usually be sent to the registered manager or registered person (e.g. nominated individual, partner, responsible individual). This is your opportunity to share your feedback on the inspection experience so we strongly encourage you to respond. We anonymise and amalgamate these survey findings and use them to help us learn and improve what we do. Some of the findings are also used for the CQC's public performance reporting.

If you have any questions about this letter, you can contact our National Customer Service Centre using the details below:

Telephone: 03000 616161

Email: HSCA_Compliance@cqc.org.uk

Write to: CQC HSCA Compliance
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Yours sincerely

Professor Ted Baker
Chief Inspector of Hospitals

London Ambulance Service NHS Trust

Inspection report

220 Waterloo Road
London
SE1 8SD
Tel: 02079215100
www.londonambulance.nhs.uk

Date of inspection visit: 2 to 7 Sept 2019
Date of publication: 03/01/2020

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Good
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

London Ambulance Service NHS Trust is the sole provider of acute ambulance services in London and is one of the largest and busiest ambulance services in the world. The trust serves a growing population of over 8.9m people in one of the most socially and culturally diverse cities. An ambulance service has been provided in London for over a hundred and twenty years from the first ambulances provided by the London Asylum Board in the 1880s, through to the creation of the LAS as it is known today (in 1965). The trust has over 5,000 people and nearly 3,500 front-line clinical staff.

LAS is overseen by the Department of Health and its services are commissioned by the 32 London Clinical Commissioning Groups (CCG), with NHS Brent CCG acting as lead on behalf of the rest of the London CCG. London Ambulance Service links to the five London Sustainability and Transformation Partnerships (STPs). Its contract with its commissioners was not, at the time of the inspection agreed.

The trust was commissioned by Bart's Health for neonatal transfer services. They were commissioned by South East London Commissioning Support Unit for Integrated Urgent Care Services (IUC) which includes 111 calls in South East London and by City and Hackney Clinical Commissioning Group for IUC which includes 111 services in North East London. They were also commissioned by Heathrow Airport for additional services.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Good 

What this trust does

London Ambulance Service NHS Trust (LAS) operates across the whole of London, providing services in a geographically small but densely populated area. It is the busiest ambulance service in the country. The trust headquarters are based in Waterloo. Responses to 999 calls are received and triaged by staff working in the Emergency operations Centres (EOC), of which there are two. As the mobile arm of the health service in London, the trust's role is to respond to emergency 999 calls, providing medical help to patients who have serious life-threatening injuries or illnesses as quickly as possible. A range of vehicles including fast response cars, cycles, ambulances and motorbikes enable the front-line staff to respond to instructions provided from the EOC.

LAS has two Integrated Urgent Care (IUC) call centres, which receive and respond to 111 calls and combine out of hours services. These centres are based in south east London (Croydon) and north east London (Barking).

There are two resilience sites, one in Isleworth and one at Newham. Staff from these sites make up the Hazard Area Response Team (HART). These paramedic staff attend major incidents and 'warm zones', working with other specialist teams to deal with and provide life-saving treatment.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

Summary of findings

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse. We inspected the Urgent and Emergency Care (U&EC) and the Emergency operations Centres, (EOC). These services were inspected because our intelligence told us there were possible safety concerns.

We also inspected the NHS 111 services, which are part of the two Integrated Urgent Care (IUC) services. These services were inspected under the primary medical services methodology because our intelligence monitoring indicated some concerns.

NHS trust's currently have a well-led inspection on an annual basis, and for this reason we also completed a well-led review. On this occasion the well-led inspection took place over one day as part of a pilot.

What we found

The ratings for Emergency Operations Centre went down from our previous inspection to requires improvements overall. The rating for Emergency and Urgent Care remained as good. Previously there was only one NHS 111 service, which had been rated as good overall. At this inspection the trust was delivering NHS 111 services from two separate locations which were rated together. The rating for the NHS 111 was good overall. We rated the well led part of this inspection as good.

Overall trust

Our rating of the trust stayed the same. We rated it as good because:

- There were enough front-line ambulance staff to care for patients and keep them safe. Staff had training in the key skills needed for their role. Most staff understood how to protect patients from abuse and managed their safety well. Managers monitored the effectiveness of the service and made sure staff were competent in their roles.
- The services-controlled infection risks and followed professional practices with this regard. Staff understood their duty to raise concerns and report incidents and near misses. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff assessed risks to patients, acted on them and kept good care records of treatment and care provided. Information was shared where required in a safe manner with other health agencies. Staff provided good care and treatment, gave patients pain relief when they needed it. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers and helped patients and their carers find further information and to access community and advocacy services.
- There were systems to alert staff to specific safety or clinical needs of a person using the service and to provide additional support. Steps were taken to respond to capacity issues by transferring calls between sites.
- Services were available seven days a week. The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. The service engaged well with patient groups and the wider community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

- Leaders ran services well using reliable information systems and supported staff to develop their skills. Most staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.
- Leaders used a range of monitoring tools to measure performance and achievement of national targets. Action was taken where improvements were needed. Complaints were responded to in line with the trust's standards.
- The service promoted equality and diversity in daily work and provided opportunities for career development. There was a general culture of inclusivity and of teamwork across services.

However:

- Despite the trust having increased the staffing in the Emergency Operations Centres, there was a lack of consistency in staffing levels and the rota system was unreliable. This impacted on staff's ability to respond to incoming telephone calls to the Emergency Operations Centres. Temporary agency staff used in IUC did not always have the required level of skill needed to provide a responsive service to callers. The availability of clinical advisors in the EOC impacted on staff's ability to get advice as quickly as needed.
- The incident reporting culture had continued to improve and there was evidence of improvements made as a result of learning from such events. There was however, some variation in EOC staffs understanding and use of the incident reporting process. Although learning from incident review processes was communicated in several ways, staff working in EOC and the IUC reported not having time to read some communications and therefore, were not aware of some updates.
- Although mandatory safety training rates had improved since the last inspection, some expected targets had not been met. Staff working in EOC had educational breaks built into their shifts but reported not having enough time to update themselves or complete on-line learning.
- Line managers in EOC and IUC were not always assessing their staff's competencies following the completion of mandatory training and regarding expected practices within their roles. There were gaps in some of the role specific training of IUC staff.
- Although appraisal rates had improved in EOC, some staff did not have the opportunity to have feedback on their performance through supervision or an annual review.
- Whilst staff had access to policies, procedural guidance and other useful information, where updates to these resources was required, action had not always been taken to do this. However, we saw systems had been put in place to address this area as soon as the matter was brought to the executive's attention.
- Although the trust had done work to improve safety and security, some areas and vehicles were still not secured to a consistent standard. The provision of equipment had improved to front line vehicles and staff, there were some items which remained less available or were not yet provided and some items had passed the expiry date. This was like our previous findings.
- The stock rotation of some locally managed medicines and consumables needed to be tightened to ensure out of date stock was identified and removed.
- The servicing of vehicles was not always happening in a timely way causing reduced availability to staff.
- Although people could access the service when they needed it, there were regular delays in responding to initial telephone calls made by the public to the EOC.

Summary of findings

- Team meetings did not routinely take place for the sharing of information and one-to-one meetings were cancelled in IUC due to demands on the service. Opportunities were sometime missed to help staff understand the priorities of the service and what was being done to manage these and other issues.
- Several staff in EOC were not fully aware of the trust's vision or how they could contribute to its achievement. Senior leaders were not as visible and approachable as staff expected, although the executive team had carried out several staff engagement activities to address this.

Are services safe?

Our rating of safe went down. We rated it as requires improvement because:

- Whilst staffing levels within the Emergency operations Centre (EOC) had improved since our last inspection, the staffing numbers and rota system in use did not enable calls to be responded to as quickly as expected and to a consistent level. The trust was however, working to address the rota and annual leave policy to improve this. The trust was working to improve staffing in the Integrated Urgent Care (IUC) service, but the departments remained short of substantive staff on a regular basis.
- Improvements had been made in the completion rates of mandatory safety training since the last inspection. Despite this some of the trust's own expected targets had not yet been met in a relatively small number of subjects. The transfer of knowledge related to safeguarding vulnerable people had not been taken on board by all staff working in the EOC, and this was not being assessed by line managers.
- Whilst there was a very well-structured incident reporting system and process, several staff in the EOC were not fully aware of this. The trust had several ways of sharing information, although staff in working in the EOC and IUC reported not having time to read information circulated. Learning from investigations and complaints was not always shared through one-to-one meetings, as a result of these being cancelled in IUC when service demands took precedence.
- Medicine storage temperature monitoring was not always carried out. Medicines which were out of date were identified in vehicles. Medicines which needed to have a start date recorded on them but did not contain this information. Some simple medicines were not returned to the original packaging after use.
- As we found at our previous inspection, some essential equipment items were not always available. Some equipment items had gone passed the expiry date, suggesting that checks were not being completed fully.
- The security and accessibility to some parts of the trust and vehicles continued to be a concern.
- The servicing of vehicles was not always happening in a timely way, which at times reduced vehicle availability to staff.

However:

- There were enough front-line staff with the right skills and abilities to deliver safe treatment and care to patients. Staff in all areas were provided with access to training to ensure they were able to fulfil their roles.
- Infection prevention and control practices were undertaken by staff according to the trust's guidance. Staff assessed the needs of patients and considered safety concerns and risks. They completed patients' records to a good standard and shared important information with other care providers where required.
- Safeguarding information was readily available to staff. The arrangements were very well established and there were high levels of reporting through the trust's safeguarding team. The trust worked with external agencies about safeguarding when required.

Summary of findings

- There was a well-defined and easily accessible process for speaking up and there was in the main, a good culture of reporting incidents. These were reviewed and investigated, and learning was shared via a range of methods, although not everyone took responsibility to read such important information.

Are services effective?

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment including pain relief based on national guidance and evidence-based practice. Care pathways were used by staff where appropriate. Front line staff had access to information via electronic devices. Managers checked to make sure staff followed professional standards of practice and other guidance. They provided clinical information updates through the trust's main intranet page and other means.
- The service monitored, and mostly met, agreed response times so that they could facilitate good outcomes for patients. The monitoring of services and performance was well established. Staff were generally aware of what was required of them in order to deliver the services efficiently. Data was collected, reviewed and used to make improvements when required.
- Staff worked in a collaborative way with one another and external agencies to ensure the needs of patients were assessed and responded to. Where advice about patients' health needs was required, staff provided this information. Staff received training on consent, the Mental Capacity act (2005) and supported patients to make informed decisions about the treatment and care.

However:

- Whilst staff had access to training and development opportunities, line managers did not always have the opportunity to hold discussions with their staff or annual performance reviews due to activity levels. The competencies of staff were not always being assessed in EOC or IUC by their line managers.
- Information that was provided to staff to help them in their roles was not always updated in light of changes in practice. The trust had taken action to address this.

Are services caring?

Our rating of caring went down. We rated it as good because:

- Most staff spoke with patients and attended to them with compassion and kindness. Their privacy and dignity was respected, and staff took into account patients individual needs. Staff demonstrated compassionate, empathetic care to patients and members of the public in often difficult and challenging circumstances.
- Emotional support was provided over the telephone or directly to patients, families and carers. Staff recognised and considered patients' personal, cultural and religious needs. They provided advice and used a range of supportive tools to delivery care safely and responsively.
- Staff supported and involved patients, families and carers to understand the situation and the required actions of staff. They involved those who were important to the patient in making decisions about their care and treatment.

Are services responsive?

Our rating of responsive stayed the same. We rated it as good because:

- Services were planned and organised around the needs of the populations served by the trust. The trust worked with a wide range of other stakeholders to evaluate and improve its services.

Summary of findings

- The trust's resource escalation action plan (REAP) enabled it to monitor increasing operational activity and manage surges in demand. There was good engagement with other acute trusts at times of high activity and the trust worked hard to avoid unnecessary hospital conveyances.
- Staff worked in ways which were inclusive and took account of people's individual needs and their choices. Staff had access to additional resources to support them in delivering treatment and care. In addition to the expertise of front-line staff there was support available to deliver advice and care through specialist staff, including mental health, end of life and maternity.
- Peoples complaints were acknowledged, investigated and responded to in line with the trust's own complaints policy. Learning from complaints was shared with relevant staff, although staff did not always read information provided by leaders.

However:

- At times of high demand and pressure staff working in the call centres were not always able to respond to incoming calls as quickly as they would like. There were safety mechanisms in place to ensure patients of priority were responded to as soon as possible.

Are services well-led?

Our rating of well-led of the service stayed the same. We rated it as good because:

- Leaders of service areas understood what was expected of them and their staff and managed the priorities and key outputs needed to run the service safely and efficiently. Leaders in service areas were visible and approachable. Leaders supported staff to develop their skills and take on additional responsibilities. Leaders encouraged an open and honest culture, which valued the contributions of staff and fostered inclusivity.
- Most staff understood what the trust's vision was and what they wanted to achieve. A range of staff had been involved in the strategy and most understood it was focused on developing and sustaining services, which were aligned to local plans within the wider health economy. Leaders and the majority of staff understood and knew how they contributed to the strategic aims and assisted in monitoring progress.
- Staff generally felt respected, supported, and valued. The staff survey for 2018 saw improvements in several areas and was responded to by more staff than previously. Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders and teams used systems to manage performance outcomes effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. There were arrangements to support staff to cope with unexpected events.
- Performance information was collected and reviewed by service level leaders. Where improvements had been made information was shared with staff. Areas which needed to improve were identified and communicated accordingly.
- Staff were encouraged to actively and openly engaged with patients and the wider community. They collaborated with partner organisations to help improve services for patients and to highlight the impact of health issues and matters such as knife crime.
- Staff recognised the importance of learning and improving services. Leaders shared information including learning from adverse situations and from complaints in a range of ways. Leaders had a good understanding of quality improvement methods and the skills to use them. Staff were encouraged to be innovative and participation in projects and research.

However:

Summary of findings

- Although there were regular opportunities to meet, discuss and learn from the performance of the service, staff in the Emergency Operations Centre (EOC) and Integrated Urgent Care (IUC)/111 reported not always having feedback of learning from incidents. They reported not having time to read information cascaded from senior leaders. Further, one-to-one meetings and team meetings were not always carried out as expected.
- Leaders within the EOC did not routinely apply leadership practices to monitor and assess staff's competencies and their understanding of the organisational services. They did not always communicate effectively so that staff understood the trust's aims and how they impacted on these.
- Some leaders in EOC reported being confused about the responsibilities for attending joint meetings between the different core services or how often meetings took place. Leaders did not have a clearly defined responsibility to raise incidents which impacted on both EOC and IUC/111 and as a result shared learning was not always happening.
- Several staff in EOC reported the executive team as being less visible than they expected, despite several engagement activities having been carried out.

Click or tap here to enter text.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services, and we used our professional judgement to reach fair and balanced ratings

Outstanding practice

We found examples of outstanding practice in well-led and the emergency and urgent care service. For more information, see the Outstanding practice section of this report.

Areas for improvement

We found areas for improvement including two breaches of legal requirements that the trust must put right. We found 18 things which the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

Action we have taken

We issue requirement notices and take enforcement action against the provider. Listing them as shown below will include action relating to all problems in the trust's services, whether they are trust-wide or at service type, location or core service level.

We issued two requirement notices to the trust. Our action related to breaches of two legal requirements at a trust-wide level.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Summary of findings

Outstanding practice

- We found the Board Assurance Framework (BAF) was very well thought out, primarily identifying major external threats to achieving the trusts high level strategic objectives and in identifying only the five main risks that were significant in this regard. Executive owners had been identified for each risk and scrutinising committees to provide assurance regarding mitigations and robust ongoing assessment.
- The trust has played a leading role in the creation of the London Digital Board and other stakeholders to shape a clearly aligned strategy for integrated working. This was strengthened during development of the One London Local Health & Care Records (LHCR) programme, which was now delivering integrated patient records across all providers in London. The trust was proud and encouraged to have the region ask LAS to lead this ground-breaking programme of work.
- The pioneering services were recognised as contributing to a responsive service and to reducing the unnecessary conveyance of some patients onwards to hospitals.

Areas for improvement

- The trust must ensure medicines are correctly stored, identifiable and batch numbers and expiry dates are clearly visible.
- Staff must take appropriate actions to secure vehicles and access to stations and improve further the restocking of equipment and the checking of expiry dates.

Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

In Emergency and Urgent Care (EUC) the trust should:

- The trust should ensure medicines are correctly stored, identifiable and batch numbers and expiry dates are clearly visible.
- The trust should ensure the arrangements to secure vehicles and equipment are improved.
- The trust should ensure that it increases visibility and opportunities of managers at all levels for the organisation to engage directly with the frontline staff.
- The trust should ensure staff have access to updated policies and guidance based upon national best practice.

In Emergency Operations Centres (EOC) the trust should:

- Improve the oversight of mandatory training completion rates to meet the trusts own target.
- Continue to work on the provision of optimum staff numbers working in both EOC's and develop the rota to support this.
- Continue to monitor the maintenance and use of facilities and premises to keep staff and other people safe**.**
- Consider how it may improve the oversight of calls response times within EOC.
- Consider how it may further improve the sharing of actions arising from patient safety alerts, that these are implemented and monitored, and staff have a good understanding of learning from incidents.
- The trust should act to ensure the clinical welfare calls are completed within the targeted timeframes.

Summary of findings

- Make sure staff have access to updated policies and guidance based upon national best practice.
- The trust should consider how it can improve the accessibility to supervision sessions, one-to-one's and to make the appraisal process more meaningful and well-structured.
- Leaders in EOC should consider how they can assess staff competencies and check their understanding of required practices.

In Integrated Urgent Care the trust should:

- Provide time for staff to complete additional duties such as completing the service's incident database.
- Consider ways to improve the use of communication tools to demonstrate the correct documentation of information is provided.
- Consider ways to effectively disseminate information to staff.

In well-led the trust should:

- The executive leaders should ensure they take all appropriate action to deliver its financial plan for 2019/20 and future years.
- Make sure that all service changes and developments proposed are endorsed by its commissioners and incorporated into contracts.
- The trust should consider how it may increase visibility of the senior leadership team.
- Further consider the opportunities for managers at all levels of the organisation to improve direct engagement with the frontline staff.
- Ensure staff have access to updated policies and guidance based upon learning from events and/or national best practice.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Our rating of well-led at the trust stayed the same. We rated well-led as good because:

- Leaders had the right skills, and abilities to run the service. They understood and managed the priorities and issues the service faced. They endeavoured to be visible and approachable in the service for patients and staff. Leaders undertook professional development and had learning opportunities. They supported staff to develop their skills and take on more senior roles. Leaders encouraged an open and honest culture, which valued the contributions of staff and fostered inclusivity and access.
- The service had a clear vision for what it wanted to achieve and a strategy to turn it into action, which had been developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and was

aligned to local plans within the wider health economy. The trust vision and strategic aims were underpinned by an ethos of providing optimum services to the whole of the population it served and for establishing a world class ambulance service. Leaders and most staff understood and knew how they contributed to the strategic aims and assisted in monitoring progress.

- Most staff felt respected, supported, and valued by the executive leadership. Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. Work was still in progress to improve the experiences of BAME staff.
- The service had an open culture where patients, their families and staff could raise concerns without fear and had these investigated and responded to.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The new services and organisation structures had led to revised financial planning, budgeting and control requirements within the trust. The finance department had been restructured and new roles in procurement and commercial services had been developed. The trust had gained substantial assurance about its internal controls from internal auditors.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- All leaders were committed to continually learning and improving services. There was challenge from the Trust Board and good oversight of performance outcomes. Governance arrangements were embedded in leadership practices and information was fed through the various committees up to the board. Leaders shared performance data and information, including learning from adverse situations and from complaints in a range of ways. Leaders had a good understanding of quality improvement methods and the skills to use them. Staff were encouraged to be innovative and participation in projects and research.
- Although leaders recognised further work needed to be done to reach the wider community, they worked with and encouraged staff to actively and openly engaged with patients, equality groups, the public and local organisations and one another to plan and manage services. They collaborated with partner organisations to help improve services for patients.

However:

- Corporate policies and procedural guidance was not always updated as a result of learning from adverse events or where best practice guidance had been revised.
- Despite their efforts, the executive team were not as visible to the wider staff community as was expected by them.
- Service changes and proposed developments were not consistently endorsed by the trust's commissioners and had not always been incorporated into contracts.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↓ Sept 2019	Good ➔➔ Sept 2019	Good ↓ Sept 2019	Good ➔➔ Sept 2019	Good ➔➔ Sept 2019	Good ➔➔ Sept 2019

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for ambulance services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Requires improvement ↓ Sept 2019	Good →← Sept 2019	Good ↓ Sept 2019	Good →← Sept 2019	Good ↑ Sept 2019	Good →← Sept 2019
Emergency operations centre (EOC)	Requires improvement →← Sept 2019	Good →← Sept 2018	Good →← Sept 2019	Good →← Sept 2019	Requires improvement ↓ Sept 2019	Requires improvement ↓ Sept 2019
Resilience	Good Jun 2016	Good Jun 2017	Not rated	Good Jun 2017	Good Jun 2017	Good Jun 2017
Integrated Urgent Care	Good Sept 2019	Requires improvement Sept 2019	Good Sept 2019	Good Sept 2019	Good Sept 2019	Good Sept 2019
Overall	Requires improvement ↓ Sept 2019	Good →← Sept 2019	Good ↓ Sept 2019	Good →← Sept 2019	Good →← Sept 2019	Good →← Sept 2019

Overall ratings are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Emergency operations centre (EOC)

Requires improvement 

Key facts and figures

London Ambulance Service NHS Trust (LAS) became an NHS Trust on 1 April 1996 and covers the Greater London area, which has a population of around 8.6 million people. The trust employs around 5000 whole time equivalent (WTE) staff.

LAS main role is to respond to emergency 999 calls, providing medical care to patients across the capital, 24-hours a day, 365 days a year. Other services include providing pre-arranged patient transport and finding hospital beds. Working with the police and the fire service, LAS also prepares for and deals with large-scale or major incidents in the capital through the hazardous area response team (HART).

LAS currently operate its control services function from the Emergency Operations Centre's (EOC). The primary focus is the management of all 999 call-taking and dispatch functions, which are split across the trust headquarters at Waterloo and at Bow EOCs. To do this the trust uses a command and control Computer Aided Dispatch (CAD) system. EOC functions include:

- Providing a command and control function, delivering call answering to all patients.
- Providing safe, effective triage to determine the most appropriate care package, thus adhering to effective clinical governance.
- Provision of regular structured welfare calls to patients who are awaiting an ambulance response.
- Distribute and dispatch the most appropriate operational patient facing resources produced by the trust on a daily basis, for example, ambulances.
- Ensure appropriate actions are taken to optimise patient care by referral and/or deployment.
- Maintain capacity and capability to co-ordinate and manage any significant/major incidents.
- Provide enhanced clinical assessments for lower acuity incidents via the LAS Clinical Hub (CHUB) or NHS 111.

LAS provides advice and dispatches ambulances and crew according to need.

The call priority categories are as follows:

- Category one: For calls to people with immediately life-threatening and time critical injuries and illnesses. These should be responded to in an average time of seven minutes.
- Category two: For emergency calls, including stroke patients. These should be responded to in an average time of 18 minutes.
- Category three: For urgent calls including patients treated by ambulance staff in their own home. These types of calls should be responded to before 120 minutes.
- Category four: For less urgent calls and patients who may be given advice over the telephone or referred to another service. These less urgent calls should be responded to within 180 minutes.

The previous comprehensive inspection of EOC took place in March 2018 where the service was rated as good overall. Effective, responsive, caring and well-led were rated good and safe was rated requires improvement.

Emergency operations centre (EOC)

During our inspection we spoke with staff including call takers, dispatchers, clinical advisors, supervisors and watch managers. We observed 999 calls, reviewed policies and a variety of performance data, including incidents, complaints and national ambulance quality indicators (AQI).

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- The service did not have always have enough staff working within both EOC's.
- Not all staff understood how to protect patients from abuse. However, the service worked well with other agencies when abuse was highlighted.
- The design, maintenance and use of facilities, premises and equipment did not always keep staff safe.
- Staff did not always have opportunity to learn from incidents and managers did not always ensure actions from patient safety incidents were implemented and monitored.
- Managers did not always appraise staff's work performance and did not always hold supervision meetings with them to provide support and development.
- At the time of inspection, staff did not always have access to updated policies.
- Staff did not always feel leaders understood and managed the priorities and issues the service faced. Leaders were not always visible and approachable in the service for staff.
- The service did not always operate effective governance processes. Staff were clear about their roles and accountabilities but did not always have regular opportunities to meet, discuss and learn from the performance of the service.

However:

- All those responsible for delivering care worked together as a team to benefit patients.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- It was easy for people to give feedback and raise concerns about care received.
- Staff were overwhelmingly positive about the culture within both EOC's and the inclusivity of the organisation.
- The trust employed a mental health nurse (RMN) who was available within EOC to offer support and guidance to staff on matters relating to patients experiencing mental ill health.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

- **The service provided mandatory training in key skills to all staff but did not ensure everyone completed it.** Information received prior to our inspection showed the service did not always meet the trust target of 85% overall completion.

Emergency operations centre (EOC)

- **Not all staff understood how to protect patients from abuse. However, the service worked well with other agencies when abuse was highlighted.** There was a mixed response from staff in identifying and recognising different types of abuse and the patient groups this applied too. However, the trust met their own target of 85% for completion of safeguarding levels 1, 2 and 3 for all staff groups.
- **The design, maintenance and use of facilities and premises did not always keep staff safe**. Staff had concerns about the security at one of the EOC locations. Staff also reported the computer-aided dispatch (CAD) system was sometimes slow to display information.
- **The service did not always identify and respond to risks well and in a timely manner**. During our inspection, we observed call handlers who were unable to gain timely advice from the clinical hub (CHUB) due to the unavailability of clinical advisors. Clinical advisors also told the inspection team that they did not feel they always had clinical oversight within EOC due to operational demand and lack of adequate staffing.
- **The service did not have always have enough staff working certain shifts with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.** Staff we spoke with told us they had concerns regarding staffing levels and management staff told us they did not always feel the service was safe. However, the trust was actively working to ensure staffing levels matched predicted demand.
- **The service did not always manage patient safety incidents well. Managers investigated incidents and shared lessons learned. However, staff did not always have the opportunity to read information. Managers did not always ensure that actions from patient safety alerts were implemented and monitored**. Staff were not always aware of learning from incidents, staff felt they had limited time to check emails, read trust bulletins and engage with their managers.

However:

- **Staff gave advice on medicines in line with national guidance.** Clinical advisors provided medicine advice to patients which was in line with The Joint Royal College Ambulance Liaison Committee (JRCALC).
- **Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.** Notes were stored securely on an electronic system which was password protected with access limited to appropriate staff.
- **The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**

Is the service effective?

Good  

Our rating of effective stayed the same. We rated it as good because:

- **The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care. However, staff did not always have access to updated policies.** Policies we reviewed during inspection were not reviewed in line with trust policy and staff reported confusion on which information to follow. After inspection, the trust demonstrated a comprehensive plan to ensure policies were up to date and contained all relevant information.
- **Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief advice in a timely way.**

Emergency operations centre (EOC)

- **All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.** We observed good working practices with other external agencies such as, police and the fire brigade.
- **Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.** Staff received training in the Mental Capacity Act (2005) and dementia awareness training.

However:

- **The service made sure staff were competent for their roles. However, managers did not always appraise staff's work performance and did not always hold supervision meetings with them to provide support and development.** At the time of inspection, appraisal rates for staff were under the trust target of 85%. Staff we spoke with did not always feel appraisals were worthwhile with limited opportunity to discuss development needs.
- **The service monitored but did not always perform well when compared to the England average**

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.** Staff demonstrated compassionate, empathetic care to patients and members of the public in extremely difficult or challenging circumstances.
- **Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.** Staff showed understanding of the impact of their advice and used relevant support tools to aid them in their delivery of care.
- **Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.** Staff demonstrated an understanding of the importance of involving patients, relatives and carers in their interactions.

Is the service responsive?

Good ➔➔

Our rating of responsive stayed the same. We rated it as good because:

- **The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**
- **The service was inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients access services.** Staff had access to an interpreting service and type-talk for patients who were deaf or speech impaired. The trust employed a mental health nurse (RMN) who was available within EOC to offer support and guidance to staff on matters relating to patients experiencing mental ill health.

Emergency operations centre (EOC)

- **It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them but did not always share lessons learned with all staff.** Complaints were investigated in line with the trusts own complaints policy and complaints were investigated and closed within the trusts target. However, there was limited understanding from staff on learning lessons and feedback from complaints.

However:

- **People could not always access the service when they needed it which was not in line with national standards and did not always receive the right care in a timely way.** Staff reported, at times, the service could be under severe pressure and patients would have a delayed wait for their call to be answered. However, the trust had a number of procedures in place to ensure high priority calls were answered as soon as possible.

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- **Leaders had the integrity, skills and abilities to run the service. However, staff did not always feel they understood and managed the priorities and issues the service faced. Senior leaders were not always visible and approachable in the service for staff.** Members of staff we spoke with did not feel they understood the role of senior managers. Middle management staff told us they did not always feel the board understood the operational pressures faced within EOC. However, staff told us they felt supported by their immediate line manager.
- **The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. However, staff did not always understand or know how to apply them and monitor progress.** Staff we spoke with did not understand the trusts vision and did not always feel invested in understanding the strategy of the service.
- **Leaders did not always operate effective governance processes. Staff were clear about their roles and accountabilities but did not always have regular opportunities to meet, discuss and learn from the performance of the service.** Staff felt the trust took governance seriously but because of operational pressures, staff did not feel they had enough time to do exactly what was expected of them. Although the trust collected data and analysed it, staff did not always feel it was used to improve the service.

However:

- **Leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact.** The EOC risk register was maintained and showed an awareness of the current risks facing the service. The trust also had a clear audit programme to monitor the quality of the service.
- **The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.** The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- **Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development.** Staff were overwhelmingly positive about the culture within both EOC's and the inclusivity of the organisation.

Outstanding practice

Emergency operations centre (EOC)

Areas for improvement

- The trust should ensure all staff have completed mandatory training subjects and that this meets the trusts own target for completion.
- The trust should ensure there are sufficient numbers of staff working in both EOC's at all times.
- The trust should ensure the maintenance and use of facilities and premises keeps staff safe**.**
- The trust should act to ensure there is good clinical oversight of all calls within EOC at all times.
- The trust should ensure actions from patient safety alerts are implemented and monitored and staff have a good understanding of learning from incidents.
- The trust should act to ensure the clinical welfare call are completed within the targeted timeframes.
- The trust should ensure staff have access to updated policies and guidance based upon national best practice.
- The trust should ensure staff have a meaningful, well-structured appraisal in line with the trusts own target.

Emergency and urgent care

Good ➔➔

Key facts and figures

London Ambulance Service NHS Trust (LAS) was established in 1965 from nine previously existing services and became an NHS Trust on 1 April 1996. LAS is overseen by the Department of Health and its services are commissioned by the 32 London Clinical Commissioning Groups (CCG), with NHS Brent CCG acting as lead on behalf of the rest of the London CCG.

They are also commissioned separately by NHS England for emergency neonatal transfers, by North West London Commissioning Support Unit for 111 services in south east London and by City and Hackney Clinical Commissioning Group for 111 services in north east London, and by Heathrow Airport for additional services. LAS plays a key role in working proactively with members of London's five sustainability and transformation partnerships to support the delivery of the Five Year Forward View and associated demand management initiatives.

London Ambulance Service NHS Trust covers the capital city of the United Kingdom, over an area of approximately 620 square miles. The LAS is the busiest ambulance service in the country and one of the busiest in the world; with demand for services increasing year on year. The services are provided to a multicultural population of around 8.9 million people, swelled by over 30 million annual visitors.

The trust has in excess of 5,500 staff, 65% of whom deliver services to the public on the frontline.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- Risk assessments were undertaken for each patient. Risks were managed well.
- Mandatory training was provided in key skills and most completed it as required.
- Patients who were at risk of deterioration where quickly identified and managed accordingly.
- On the whole the service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Records were clear and up-to-date, we found they were stored securely and were easily available.

Patient safety incidents were managed well. Staff understood their responsibility with regards to incident reporting. Incidents were investigated and learning was shared with staff.

- All patients were partners in their care, they were supported by staff to understand their treatment and to make decisions about their care**.**
- Patients were provided with information on how to make healthier lifestyle choices.
- Staff were supported by clinical experts who gave advice to ensure patients received the correct treatment and care.
- Date was used by the service to analyse how it was performing. Data was accessible to staff when it was needed.

However

- Security at station was still an issue, stations and vehicles were left unlocked. Certain pieces of equipment were routinely not available for staff to use as part of their daily work.

Emergency and urgent care

- Fleet staff did not receive training in the new ambulance vehicles the service were introducing to the fleet.
- The storage of medicines in kit bags needed to improve. The stock rotation of some consumables needed to be tightened to ensure out of date stock was identified and removed.
- The trusts policies and procedures were not always updated in a timely manner.
- Managers were not always visible and approachable for staff and patients. Staff were not always supported by managers to develop their skills.

Is the service safe?

Requires improvement 

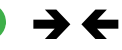
Our rating of safe went down. We rated it as requires improvement because:

- **The design, maintenance and use of facilities, premises, vehicles and equipment did not always keep people and equipment safe. However, staff were not always trained to use them. Staff managed clinical waste well. However, we found issues with security at some of the stations visited.**
- **The service used systems and processes to safely diagnose, then treat with, administer, record and store medicines. However, there were some areas which needed improvements.**

However

- **The service provided mandatory training in key skills including the highest level of life support training to all staff and most staff completed it.**
- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**
- **The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and premises visibly clean. Staff managed clinical waste well.**

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good because:

- **Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief advice in a timely way.**
- **The service monitored, and mostly met, agreed response times so that they could facilitate good outcomes for patients. They used the findings to make improvements.**
- **The service made sure staff were competent for their roles. Managers appraised most staff's work performance and held supervision meetings with them to provide support and development.**
- **All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.**

Emergency and urgent care

However

- **The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. However, polices were not always updated by the responsible members of the executive team when there were changes to national guidance or as a result of learning from adverse events.**

Is the service caring?

Good ↓

Our rating of caring went down. We rated it as good because:

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- **Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.**
- **Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**

Is the service responsive?

Good → ←

Our rating of responsive stayed the same. We rated it as good because:

- **The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**
- **The service was inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients access services.**
- **People could access the service when they needed it, in line with national standards, and received the right care in a timely way.**
- **It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.**

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good because:

Emergency and urgent care

- **The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**
- **Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and within provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**
- **Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**
- **Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**

However

- **The majority of the leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Managers at all levels were not always visible and approachable in the service for patients and staff. They did not always support staff to develop their skills.**

Outstanding practice

Areas for improvement

- The trust should ensure medicines are correctly stored, identifiable and batch numbers and expiry dates are clearly visible.
- The trust should ensure the arrangements to secure vehicles and equipment are improved.
- The trust should ensure that it increases visibility and opportunities of managers at all levels for the organisation to engage directly with the frontline staff.
- The trust should ensure staff have access to updated policies and guidance based upon national best practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Our inspection team

Carolyn Jenkinson, Head of Hospitals Inspection led this inspection. An executive reviewer, Stephen Posey, supported our inspection of well-led for the trust overall.

The team included 4 inspectors, 7 specialist advisers and 2 inspection managers.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.

London Ambulance Service Headquarters

Inspection report

220 Waterloo Road
London
SE1 8SD

Date of inspection visit:
03/09/2019

Date of publication:
3 January 2020

Tel: 02079215100
www.londonambulance.nhs.uk

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	**Good**
Are services safe?	**Good**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Overall summary

We carried out an inspection of the London Ambulance Service between 2, 6 and September 2019 and 13 September 2019. Three core services were inspected: 111 Integrated Urgent Care Clinical Assessment Service, the Urgent and Emergency Service and the Emergency Operations Centre. The inspection of these services was conducted as a result of a number of whistleblowing concerns from different staff members across two of the services, over a period of one to two months.

This report covers the inspection of the London Ambulance Service's (LAS) 111 Integrated Urgent Care Clinical Assessment Services in south east London (SEL) and north east London (NEL). NEL was visited on 3 September 2019 and SEL was visited on the 5 and 13 September 2019.

The 111 services have been rated as **good** overall.

The key questions are rated as:

Are services safe? – Good
Are services effective? – Requires improvement
Are services caring? – Good
Are services responsive? – Good
Are services well-led? – Good

At this inspection we found:

- Staff were supported in the effective use of NHS Pathways which is a triage software utilised by the National Health Service to triage public telephone calls for medical care and emergency medical services.
- However, we found that not all staff were aware of how to deal with complex calls.
- The service had not met all the National Quality Reporting standards and those requirements set by the commissioners.
- The service had good systems to manage risk so that safety incidents were less likely to happen. Learning from incidents was shared at and between the two sites; however, some staff reported that they were not routinely made aware of incidents that occurred.
- The service routinely reviewed the effectiveness and appropriateness of the care it provided.
- Call audits were in place to monitor the performance of staff at each service.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- The services had an overarching governance framework in place, including policies and protocols which had been developed at a provider level and had been adapted to meet the needs of the services locally.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- The provider was in the early stages of starting a patient participation forum at a regional level so that patients could feed into the services being provided.

The areas where the provider **should** make improvements are:

- Provide time for staff to complete additional duties such as completing the service's incident database.

- Consider ways to improve the use of communication tools to demonstrate the correct documentation of information is provided.

- Consider ways to effectively disseminate information to staff.

Dr Rosie Benneyworth BM BS BMedSci MRCGP
Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector who was accompanied by a GP specialist adviser, a second CQC inspector and a manager specialist adviser.

Background to London Ambulance Service Headquarters

The London Ambulance Service NHS Trust (LAS) was established in 1965 from nine previously existing services and became an NHS Trust on 1 April 1996. The main role of the LAS is to respond to emergency 999 calls, 24 hours a day, 365 days a year. LAS has delivered a 111 service in south east London (SEL) since 2013 when it became the step-in provider; SEL 111 covers the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark. Its offices are based in Southern House, Croydon (5 minutes' walk from East Croydon station). The 111-service transitioned to an integrated urgent care (IUC) service through phased mobilisation from 26th February to 8th May 2019.

LAS was awarded, through open tender, the contract to deliver the Integrated Urgent Care (IUC) Clinical Assessment Service (CAS) for the boroughs of Barking & Dagenham, City & Hackney, Havering, Newham, Redbridge, Tower Hamlets and Waltham Forest, which commenced in 1 August 2018. This north east London (NEL) service is based at Maritime House, Barking (five minutes' walk from Barking station). Both locations were visited as part of the inspection.

In line with the national specification, the new LAS IUC CAS has a multidisciplinary team of GPs, Advanced Practitioners, Pharmacists, Nurses, Paramedics, Health & Service Advisors providing expert advice over the phone and working closely with other urgent care services in the area as part of the overall integrated urgent care system. The model for an IUC CAS requires access to urgent care via NHS 111, either on a free-to-call telephone number or online. The service provides:

- Triage by a Health Advisor;
- Consultation with a clinician using a clinical decision support system or an agreed clinical protocol to complete the episode on the telephone where possible;
- Direct booking post clinical assessment into a face-to-face service where necessary;
- Electronic prescription;
- Self-help information delivered to the patient.

Are services safe?

Good

We rated the service as good for providing safe services

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse.

- The provider conducted safety risk assessments. It had safety policies, which were regularly reviewed and communicated to staff. Staff received safety information from the provider as part of their induction and refresher training. The provider had systems to safeguard children and vulnerable adults from abuse. The staff we spoke with were clear about their responsibilities and could outline to whom to report.
- The service worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider had recruitment policies and protocols in place. The service utilised several temporary agency staff, and in files we checked there were appropriate records of references having been checked.
- Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- As part of the inspection, we reviewed the staff training log for both locations. Safeguarding training had a target of 100%; between March 2018 and April 2019, SEL achieved between 84% and 98%. Following the inspection, the provider informed us that the Trust's compliance rate was in fact 85% which they had exceeded at both sites.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- When there were changes to services or staff the provider assessed and monitored the impact on safety. The services had an action plans in place and had systems for work-force planning to ensure that shift rotas matched the demand of the services.
- Although, there were arrangements for planning and monitoring the number and mix of staff needed, six out of twenty members of staff, across both sites, told us there was insufficient staffing at both sites. We noted that notwithstanding the use of agency staff there were gaps in rotas that were not filled. Staff told us that at busy times during the winter period there had been insufficient clinical cover, although all staff said there had been an improvement with rota fills within the last few months. Rotas showed these issues had reduced in the past three months. The provider supplied details of the number of agency hours used for each service. This data showed a clear increase in agency usage, with spikes at expected times such as Easter and bank holidays. This showed they were responsive to demand, as improved performance during a busy May 2019 indicated.
- The provider told us that they were still actively recruiting for clinicians and clinical health advisers, and that the expansion of the business, particularly in SEL, which had only

mobilised into a clinical assessment service in May 2019, had meant that some rota gaps could not be filled in the short term.
- There was an effective induction system for staff, tailored to their role.
- The provider had identified that additional learning for staff was required.
- Systems were in place to manage people who experienced long waits.
- In the main, staff told patients when to seek further help and advised patients what to do if their condition got worse. However, we were told of an occasion when a health advisor had not provided worsening advice to a patient to help them respond to any difficulties that may present after they got off the call. The member of staff was given additional training and learning was forwarded to the wider team.
- Complex calls had a criterion and a caveat that if a health advisor felt out of their depth, they could request a clinician take over management of the call.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- Both sites had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. This included care homes and mental health sites.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Track record on safety

The sites had a good safety record.

- There was a system in place for receiving and acting on safety alerts.
- The sites had ‘learning from experience’ and ‘top tips’ boards to share staff experience and learning.
- There were comprehensive risk assessments in relation to safety issues.
- Both sites services monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned, and improvements made

The processes in place for shared learning was not always effective.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. All significant events had been reviewed and an action plan created for staff. The events were displayed on a screen in the call centre and were placed in a folder on each desk. However, three members of staff we spoke with said they were not always formally notified of incidents and the related learning.
- There were adequate systems for reviewing and investigating when things went wrong. The sites learned and shared lessons, identified themes and acted to improve safety. In all cases where there had been an error in the management of the call by a call handler, there were recorded details of the learning points. We reviewed a significant event which led to the provider changing the pathway of children up to one years old; this patient group must

now always be forwarded to a GP on site, rather than another clinician or being told they will receive a call back within a particular timeframe.

- The sites learned from external safety events and patient safety alerts. There was an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff.

Are services effective?

Requires improvement

We rated the service as requires improvement for providing effective services because:

- Systems failed to identify issues with staff training such as staff knowing how to deal with complex calls and knowing when to escalate concerns.
- NEL was below target for referral and management of patients with the clinical assessment service between August 2018 and May 2019.
- There were areas where both sites were below national targets.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence-based practice.

- Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. The provider monitored that these guidelines were followed. These were available on the intranet system and were emailed to staff.
- Telephone assessments were carried out using a purpose-built operating model which included processes for assessing patients' symptoms through a triage algorithm, with options including transferring the call to a clinician for further review.
- Patients' needs were fully assessed. This included their clinical and mental health needs and their physical wellbeing. Where patients' needs could not be met by the service, staff redirected them to the appropriate service.
- Care and treatment were delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with repeat patients, including engaging with the local NHS acute trust to share information, to identify, monitor and support patients who frequently called the NHS 111 service and those who also frequently attended the hospital emergency department.
- There was a system in place to identify frequent callers and patients with needs, for example palliative care patients. Care plans and protocols were in place to provide the appropriate information and support.
- When staff were not able to make a direct appointment on behalf of the patient, clear referral processes were in place. These were agreed with senior staff and a clear explanation was given to the patient or person calling on their behalf.

Monitoring care and treatment

- The provider implemented a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. The provider could demonstrate how it ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.

- Providers of NHS 111 sites are required to submit call data every month to NHS England by way of the Minimum Data Set (MDS). The MDS is used to show the efficiency and effectiveness of NHS 111 providers.
- We saw the most recent results for the sites which showed the provider was performing in line with national averages in some areas but below national averages in others, as detailed below:

North East London (between August 2018 and May 2019):

- The average time to answer a call was between 0.13 and 0.26 seconds. The national target is that 95% of calls should be answered within 60 seconds. NEL met this target in May 2019 scoring 96%"
- The service was consistently below target for referral and management of patients with the clinical assessment service. The provider had developed categories of patients to be managed within a specific timeframe depending on their needs, this ranged from P1 to P6. Patients within the P1 category should be called back within 15 mins from them making the call. We saw that between August 2018 and May 2019 the sites performance was between 46% and 74% (KPI 95%).
- In May 2019, the percentage of calls re-triaged to other sites was 93% and the percentage of ambulance avoidance due to re-triage was 89%.
- The KPI for patients with a life-threatening condition having an ambulance dispatched within three minutes of the call was 100%. The service achieved between 95% and 100%.
- During May 2019, 25% of calls were closed as self-care, the target for this is 33%.
- 99% of frequent users were consistently highlighted to their GP.
- During the period the service achieved the KPI target of 95%, seven out of 10 times, for a post event message to be sent to a patient's GP practice by 8am the following day.
- The percentage of calls answered within 60 seconds was between 82% and 91% from between August 2018 and April 2019, in May the service reached 96%. In August the England average was: 80%. (national target 95% or above, KPI 95% or above);
- The percentage of answered calls transferred to a clinical advisor with the patient still on the line was 33.38% (England average 40%).

South East London (between March 2018 and April 2019):

The service saw improvements to the abandonment rate and calls answered in 60 seconds.

- The percentage of calls answered within 60 seconds was between 74% and 93% (national target 95%, KPI 95%);
- Proportion of calls given category 3 or 4 ambulance disposition (ambulance response categories) that were revalidated (confirmed as dispatched appropriately) was (between August 2018 and April 2019) between 53% and 76% (national target 50% or more, KPI 50% or more).

- The percentage of calls triaged that were dealt with by a clinician was 64% for March 2019 and 71% for April 2019 (national target 50% or more, KPI 50% or more).
- The proportion of calls where the person was called back within 10 mins ranged between 39.4% and 66% (national target 50% or above, KPI 50% or above).
- 100% of frequent users were highlighted to their GP.

Both services were performing well for the percentage of calls assessed by a clinician and the proportion of category 3 or 4 ambulance dispositions that were revalidated. Most of the other national metrics were below target, but the service generally performed well against local KPIs. We saw that the service had a year-on-year increase in call volumes each month, figures showed that in May 2019, the service had 22% more calls than in May 2018.

We discussed the areas where the where the services were below some of the performance indicators and were informed that it had been acknowledged that the service model assumptions made during procurement required further work and evaluation. The London Ambulance Service and commissioners are currently adjusting the priority categories and considering new metrics, this is aligned with the national review of KPI's for IUC 111CAS services. Prior to the inspection we spoke with one of the commissioners whom informed us that 'call abandonment rate' (for which the provider was performing well) was the most important metric to demonstrate accessibility for patients.

In addition, the provider had an action plan in place to address the areas where performance was below national standards. Recruitment had been ongoing, and staff told us that this issue had improved, which was reflected in better results in May 2019. The provider utilised work force planning software to forecast the number of staff needed to effectively run the service. The staff rota showed that in the past two months the percentage of staff scheduled on shifts had improved.

- The service made improvements using completed audits. Audits had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality. We saw an audit of the referrals to 999 between April 2019 and May 2019. Clinicians producing a high number of inappropriate ambulance dispositions received additional coaching and increased call auditing.

Effective staffing

In the main, staff demonstrated the skills, knowledge and experience to carry out their roles. However, more needed to be done to ensure that they had received the necessary training and support. Although, there were clear clinical pathways and protocols the services had not ensured that this were fully understood by all staff.

- The staff we spoke to understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example, sepsis. In line with guidance, patients were prioritised appropriately for care and treatment. Although there were areas which required improvement, as we noted that nine out of 13 of the significant events recorded between February 2018 and July 2019 involved health advisors not following the correct pathway, having difficulty assessing patients with more than one symptom or deviating from policy. Following the inspection, we were informed that an approved audit tool for senior clinicians and NHS Pathways had been completed to allow full review of assessments. This allows full awareness of the call flow and how an individual managed a call and or the IT processes and facilitates feedback and learning to continue to improve the service provided. In addition, telephony and system reporting on individual productivity and

performance allows easy identification of abnormal behaviour that triggers further investigation.
This was evidenced in a recent incident where short calls were identified resulting in learning and continued improvement. During the inspection we were told that a 24/7 clinical navigator consistently monitors the clinical queue. Where an error in decision is identified, the case will be amended and fedback to the member of staff in real time. Depending on the severity or frequency, this will be reported to line managers to be addressed. Any immediate concern will be actioned by a duty supervisor in real time and reported on the trust incident reporting system to ensure shared learning.

- Although staff across both sites informed us that they felt supported by senior staff, we saw one-to-one meetings were occasionally cancelled due to operational pressures on the service. The commencement of the North East London service in August 2018 meant that appraisals for all staff became necessary from 1 August 2019. We saw a plan to commence and stagger appraisals from the end of September 2019 and to routinely hold one-to- one meetings. Following the inspection, the provider informed us that one-to-one meetings were cancelled from time to time due to service requirements but had all been rescheduled as a result of this.
- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained.
- All staff had received training in equality and diversity. Clinical staff undertook training on learning disabilities on joining and completed the Care Certificate Standard 9: Mental Health and Learning Disability.
- Staff undertook refresher training on learning disabilities in 2014 and Dementia in 2017. The provider used a case study of a patient with a Learning Disability in their December 2018 Safeguarding Newsletter, to share learning from a case involving an elderly patient with learning disability.
- There was a clear approach through the service's quality audit programme, for supporting and managing staff when their performance was poor or variable. Measures included direct staff feedback, mentoring and supervision.
- Both services carried out daily 'Huddle' meetings to debrief and share information with staff.

Coordinating care and treatment

- The services worked well to protect the wider system by ensuring that only where there was a clinical need would a patient get referred for a face-to-face consultation. For example, the proportion of calls where a caller was given an appointment with an integrated urgent care treatment centre or with an extended hours GP finished at 85.9% in March 2019. This is within the target of 95% or less.
- In addition, in March 2019 there was a 0.4 percentage point increase in referrals from SEL to the emergency treatment centre in comparison to February 2019. This was the fourth consecutive month that this measure had remained below the 10% target. The 9.5% figure for March 2019 was lower than for the same month in 2018 (9.8%) and 3.3 percentage points lower when compared to March 2017 (12.8%). This continued to help reduce the pressure on urgent care services in South East London.
- The percentage of calls transferred to the clinical assessment service (CAS) is targeted at over 50% in year one and the services have maintained this level since September 2018.

Currently over 20,000 calls each month are transferred to CAS, then called back according to priority.

- We saw that referrals from the Emergency Operation Centre, the 999 call-handling team and their clinical advisers, almost doubled since last year's total of 652, to 1,250. This was due to improvements in training across the 999 and 111 services.
- There were clear and effective arrangements for booking appointments, transfers to other services, and dispatching ambulances for people that required them. Staff were empowered to make direct referrals and or appointments for patients with other services.
- Staff worked together and worked well with other organisations to deliver effective care and treatment. We saw examples, of regular liaison with care homes and mental health services.
- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centered care. This included when they moved between services, when they were referred, or after they were discharged from hospital. Care and treatment for patients in vulnerable circumstances was coordinated with other services. Staff communicated promptly with patients' registered GPs so that the GP was aware of the need for further action. There were established pathways for staff to follow to ensure callers were referred to other services for support as required.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- The service ensured that care was delivered in a coordinated way and considered the needs of different patients, including those who may be vulnerable because of their circumstances.
- Issues with the Directory of Services (a database of the services available to support patients) were resolved in a timely manner. We saw that changes were made where relevant, including the prioritising of specialist services.

Helping patients to live healthier lives

Staff were consistent and proactive in empowering patients and supporting them to manage their own health and maximise their independence.

- The service identified patients who may needed extra support such as through alerts on the computer system.
- Where appropriate, staff gave people advice, so they could self-care. Systems were available to facilitate this.

Consent to care and treatment

Both services obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The provider monitored the process for seeking consent appropriately.

Are services caring?

Good

We rated the service as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The services gave patients timely support and information. Health advisors gave people who phoned into the service clear information. There were arrangements and systems in place to support staff to respond to people with specific health care needs such as end of life care and those who had mental health needs including training, awareness seminars and bulletins.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language or had hearing difficulties.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.
- Staff communicated with people in a way that they could understand.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

Results from the service's last three-month patient survey showed that at South East London (the services were monitored on slightly different criteria):

- 92% of patients said they would recommend the service to friends and family.
- 81% of patients were satisfied with the service they received.
- 78% of patients said they found the service very useful.
- 68% of patients confirmed that they felt better a week later after receiving care from the 111 clinical assessment service.

Results from the service's last three-month patient survey showed that at North East London:

- 95% of patients said they would recommend the service to friends and family.
- 78% of patients said they found the service very useful.
- 56% of patients confirmed that they felt better a week later after receiving care from the 111 clinical assessment service.
- 69% of patients accessing the service were from black and minority ethnic groups (BAME).

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- We saw that staff respected patients' confidentiality.
- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Are services responsive to people's needs?

Good

We rated the service as good for providing responsive services.

Responding to and meeting people's needs

The services organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The services understood the needs of the population and tailored services in response to those needs by providing access to local and regional out of hours bases.
- The services had weekly contract meetings with the commissioner to discuss performance issues and where improvements could be made. The service was actively engaged in contract monitoring activity with commissioners and had made several commitments to address performance issues including National Quality Requirement statistics.
- The services had a system in place that alerted staff to any specific safety or clinical needs of a person using the service. For example, there were alerts about a people being on the end of life pathway and repeat callers. Care pathways were appropriate for patients with specific needs, for example those at the end of their life, babies, children and young people.
- The service had regular end-to-end reviews with commissioners and other providers have increased the understanding of an IUC, wider system working and to improve patient care.
- Through population analysis the service (SEL) determined that 70% of patients with sickle cell disease (an inherited haemoglobin condition which affects a higher percentage of people with an African or Caribbean background) lived in London and were looking into ways to provide additional support for this group.

Timely access to the service

In the main, patients could access care and treatment from the service within an appropriate timescale for their needs.

- North East London (between August 2018 and May 2019):
    - The abandoned call rate was between 0.9% and 6.1%, the national target and commissioner key performance indicator (KPI) were both 5% or less.
- South East London (between August 2018 and May 2019):
    - The abandoned call rate was between 0.8% and 3.5%, the national target and commissioner key performance indicator (KPI) were both 5% or less.

- Patients could access care and treatment at a time to suit them. The NHS 111 services operated 24 hours a day.
- The services had introduced a system by which patients could access 111 services electronically rather than by telephone.
- The provider was aware of the areas where the services were not meeting targets and we saw evidence that attempts had been made to address them through close working their commissioners. Measures included advanced monitoring and reporting of performance data, recruitment of staff and increased use of call handling networking capabilities across the provider's network. For example, transferring calls between sites if the other location had more capacity.
- Patients with the most urgent needs had their care and treatment prioritised.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately and in a timely manner to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. 106 complaints were received in the last year across both sites. We reviewed 27 of the complaints and found that all were satisfactorily handled in a timely way. We saw that the electronic database had a record of every step of the process of handling the complaint from receipt through to resolution. Letters of apology detailing the findings of the investigations were clear and sufficiently detailed.
- Issues were investigated across relevant providers, and staff were able to feedback to other parts of the patient pathway where relevant. For example, where patient notes were not available from the patient's NHS GP practice, this was fed back to the provider and relevant GP Practice.
- The service learned lessons from individual concerns and complaints and from analysis of trends. It acted as a result to improve the quality of care. We saw learning from complaints and other patient feedback being shared through the service's internal bulletin, in developing staff training packages, and through management of staff performance. However, three members of staff stated that they were not always formally informed of incidents and tended to hear about concerns that arose through word-of-mouth.
- Since August 2018, NEL has received four formal complaints and seven informal concerns raised by patients regarding disconnecting of calls. The service carried out an investigation which involved an audit of the calls. To mitigate further, daily reports of short calls were being reviewed.

Are services well-led?

Good

We rated the services as good for being well led.

Leadership capacity and capability

Leaders were forthcoming about the issues faced at both sites and had liaised with commissioners to discuss the challenges and develop contingency plans.

- Leaders had the experience, capacity and skills to deliver the service strategy and address risks to it.
- Managers at the services were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them and had developed action plans so that these areas might be addressed.
- Staff at both sites told us that leaders at all levels were visible, and that they worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. However, we noted that NEL was managed by one centre manager who had responsibility for 24 members of the leadership team. At SEL the centre manager was responsible for 32 members of the leadership team.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

Vision and strategy

The services had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- Both services were staffed through an agency, although this had the effect of ensuring rota gaps were filled, particularly in periods of high demand we were informed by staff that during winter periods both services experienced staff shortages. A review of the services rotas showed there were occasions when both services were below their target for the number of clinical advisors required on shift. However, they were operating with a clinically safe rota which covered all shifts. We were informed that both services were trying to employ additional GPs but that this was an ongoing challenge.
- There was a clear vision and set of values. The provider had a realistic strategy and supporting business plans to achieve priorities.
- The provider developed its vision, values and strategy jointly with staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The provider planned the service to meet the needs of the local population.
- The provider monitored progress against delivery of the strategy.
- The provider ensured that staff who worked away from the main base felt engaged in the delivery of the provider's vision and values.

Culture

The services had a culture of high-quality sustainable care. However, low staffing levels and information not being shared had impacted upon this.

- Most staff told us that they felt respected, supported and valued. One out of the twelve members of staff we spoke to at SEL said that they felt some senior staff were not approachable. All staff told us that they were proud to work for their service.

- There were processes for providing all staff with the development they needed.
- The services focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. However, additional work was needed to ensure staff received information related to learning from incidents.
- The staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services were meant to promote interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding.
- Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

The provider had clear processes for managing risks, issues and performance.

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The provider had processes to manage current and future performance of the service. Performance of employed clinical staff could be demonstrated through audit of their consultations and referral decisions. Leaders had oversight of MHRA alerts, incidents, and complaints. Leaders also had a good understanding of service performance against the national and local key performance indicators. Performance was regularly discussed at senior management and board level.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality.
- The provider implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.
- We saw that the provider had a ‘themed action plan’ which detailed action to be taken to address themes (in significant event and incidents) through ‘human factors’ training within the core skills refresher; with patient management system, education and IT to make the patient electronic referral system more compliant with human factors principles.
- The provider had plans in place and had trained staff for major incidents. The system crashed in both July and August, as a result of national system failures and we were informed by staff that the service escalation plan was implemented effectively to manage the service throughout.

- One member of staff at NEL stated that when calls have been incorrectly triaged by call handlers the service's incident database should be completed. However, the database was not completed on all occasions due to the amount of time it takes to complete the form.
- One member of staff at the NEL site told us that when clinical advisors seek clinical advice from the clinical navigators (CA), the process should be done through the service's telephone advice line. This ensures that the details of the conversation are recorded. However, we were told that clinical advisors sometimes speak with the clinical navigators face-to-face. This could lead to the information given by the CA being documented incorrectly.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- One of the GPs expressed confusion about the service's prescribing policy stating that some GPs prescribe contraception while others refuse to do so. We saw that the provider had a comprehensive prescribing policy in place which permitted the repeat prescribing (where the prescription was started and continued at the patient's GP practice) of a contraceptive pill.
- A member of staff at the NEL site told us the manager does not always know how to rectify issues with the directory of services (A central directory that is integrated with NHS Pathways and is automatically accessed if the patient does not require an ambulance or by any attending clinician in the urgent and emergency care services). This sometimes results in long waiting times for patients to be referred to the appropriate service. Following the inspection, the provider informed us that the directory of services (DOS) is not a database the services control. Responsibility for the DOS lies with clinical commissioning groups.
- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- The service used performance information which was reported and monitored, and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The service used information technology systems to monitor and improve the quality of care. There were developed services by which the provider was able to work force plan.
- The service submitted data or notifications to external organisations as required.
- There were effective arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

Both services had begun the process of involving patients and the public, to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. The provider in conjunction with the out-of-hours providers in the area met regularly with the CCGs for which it had responsibility and shared information with them as relevant.
- Staff could describe the systems in place to give feedback, including written through feedback forms, staff surveys and verbal feedback through internal meetings and service delivery managers. We saw evidence of the most recent staff survey and how the findings were fed back to staff.
- The service was transparent, collaborative and open with stakeholders about performance.

- At the time of inspection, the SEL service was trialling telephone surveys for patients.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- Staff knew about improvement methods and had the skills to use them.
- The service made use of weekly reviews of incidents and complaints. Learning was shared and used to make improvements. Although, there were areas for improvement in relation to ensuring the information was disseminated to all staff.
- There were systems to support improvement and innovation work.
- The provider had plans in place to start a patient participation group to allow interested parties to be actively involved in the running of their service.
- The provider had commissioned an Advanced Nurse Practitioner training programme to support the services' clinical needs and develop staff suited to their specific requirements. The provider has become accredited to undertake GP training.
- The provider planned to fully integrate the two services with 999 for one day ('Perfect Day') to see if they can measure their deliverables.

London Ambulance Services NHS Trust

Evidence appendix

220 Waterloo Road
London
SE1 8SD

Tel: 020 7783 2000
www.londonambulance.nhs.net

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

London Ambulance Service NHS Trust (LAS) operates in a geographically small and densely populated urban areas. It is, however, the busiest ambulance service in the country. In 2017/18 the trust responded to nearly one million face-to-face call outs, to a population of 8.8 million. They also had the second highest number of face to face incidents per ambulance station, with 12.9 thousand per station, in comparison to all but one other ambulance trust, having between 4.2 and 8.3 thousand per station per year.

The trust is governed by a trust board which meets bi-monthly. The board is made up of 18 members, eight non-executive directors, nine executive directors (including the chief executive) and an associate non-executive director. The executive committee consists of the executive directors on the trust board and five non-executive directors.

The trust works closely with hospitals, other healthcare professionals and other emergency services. It is central to the emergency response to major incidents and terrorist threats in the capital.

The trust headquarters are based in Waterloo, where there is also one ambulance station and one emergency operations centre (EOC). The latter receive, triage and arrange the response to 999 calls. A second EOC is located in Bow. There are two resilience sites, one in Lambeth and one at Tower Hamlets.

LAS has two integrated 111 call centres, which receive and respond to 111 calls. These are based in south east London (Croydon) and north east London (Barking).

There are six training centres where staff receive their clinical training and education, five centres are specifically for clinical training, four of which are co-located with ambulance stations, and one is a standalone EOC training centre.

As the mobile arm of the health service in London, the trust's role is to respond to emergency 999 calls, getting medical help to patients who have serious life-threatening injuries or illnesses as quickly as possible.

From November 2017, the way in which the trust categorised emergency calls changed in line with new standards introduced across the country. The trust works to achieve the following targets:

- Category one: Average response time of seven minutes.
- Category two: Average response time of 18 minutes.
- Category three: Responded to at least nine out of 10 times within 120 minutes.
- Category four: Some of these patients will be given advice over the telephone or referred to another service such as a GP or pharmacist. These less urgent calls will be responded to at least nine out of 10 times within 180 minutes.

The trust has over 5,700 staff based at ambulance stations and support offices across London. The emergency response service is split into five operational areas across London:

- north west
- north central
- north east
- south west
- south east

(Source: Trust website www.londonambulance.nhs.uk)

Locations at the trust

The trust has a total of 68 ambulance stations across London which, for management purposes, sit within 26 local operational areas known as group stations.

The nine provider wide teams included departments such as finance, workforce, back-office functions, fleet and logistical services, NHS 111 call centres, a patient experience group and public education programme group.

Currently there are 25 stations which have secure drug facilities. There is one central logistics store located in Deptford. 12 stations have vehicle maintenance facilities, 14 contain make-ready sites, which clean and restock and prepare ambulances. Two sites house and dispatch non-emergency transport services (NETS), and NETS also operate from three ambulance stations. The trust has two sites which house and dispatch the hazardous Area Response Teams.

A breakdown of core services at the trust and number of locations is shown in the table below:

Core service	Number of locations/teams
Urgent and emergency care	68
Other	9
Emergency operation centre	4
Resilience	2
Total	**83**

(Source: Trust Provider Information Request – Sites)

Is this organisation well-led?

Leadership

Leaders had the skills, and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff, although staff in the Emergency Operations Centre felt they were less visible. Leaders supported staff to develop their skills and take on more senior roles.

Board Members

The trusts' chair had been with the service since 2016, they were supported by a deputy chair, who had been part of the non-executive team since 2014. There was one associate non-executive director (NED) and six further NEDs, with varying lengths of service. Since the previous inspection there had been some changes in the executive team, including the new role of a chief operating officer, the director of communications and engagement and the director of people and culture.

There had been some improvement in the membership of the representation from Black Asian and Minority Ethnic (BAME) on the trust board since the previous inspection. Of the executive board members at the trust, 10% were Black Asian and Minority Ethnic (BAME) and 60% were female.

Of the non-executive board members 22.0% were BAME and 33.0% were female.

Staff group	BME %	Female %
Executive directors	10.0%	60.0%
Non-executive directors	22.0%	33.0%
All board members	15.8%	47.0%

(Source: Trust Information Requested after revised recruitment update)

In the last year there had been turnover and change at the board level. The induction process for board members developed prior to our last inspection was still in use, as was an induction handbook. Since the last inspection a board management software had been put into use, which together with the other resources, was said to provide a clearer welcome process.

The director of corporate governance told us there was a collective board development programme, with bi-monthly board and bi-monthly divisional sessions. The latter were ad hoc, but a formal structure was now in place for 2019/20. During the June divisional session there had been a focus on engagement. The non-executive directors (NEDs) we spoke with said the development sessions were extremely helpful.

We asked about executive team development and were told there were new members in the executive team, which meant development was required, taking into consideration the different backgrounds and skills of those who had joined the team. An away day had been held during which they completed personality inventories. Development time was now a monthly half day, which they felt was more productive.

We reviewed the trust's fit and proper person policy in conjunction with several personnel files for the executives and non-executives. This was to see if members of the executive and non-executive team were employed were in line with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Our initial review found the files were not maintained in accordance with the details outlined in the trust's own policy. For example, we could not see evidence of the interview/competence assessment of executives; this included those who were recruited via an external agency. References were not visible in some files, and it was not clear if the assessment had included any values-based questions. We raised this with a member of the executive team and were told some of the information was held separately. Subsequently, we were provided with informal discussion panel notes and competency-based interview notes for two of the most recently appointed executives. We were able to view appraisals and other information which had been stored within an electronic record for each member of the executive and non-executive team.

Similar to our last inspection, we found the executive team had a broad range of skills, knowledge and experience. In our discussions they demonstrated a commitment to the trust, a desire to support the strategic objectives, and were open and honest in their contributions. Executive leaders and the trust board were described very positively by staff we spoke with prior to the inspection. This included positive comments on their approachability and visibility. We noted however, there was some variation in this across staff groups, including those working in the

Emergency Operations Centre (EOC). Some staff in EOC told us in the core service inspection they did not see executive leaders. The executive team were fully aware of the need to increase their visibility. The medical director said, 'we need to get better at broadcasting we are out and about' and gave an example of how they worked over the bank holiday with frontline staff, but staff in EOC were not aware of this.

The relationship between the chair and chief executive officer (CEO) was described to us favourably, both being 'strong and ambitious', and 'pushing each other to achieve.' They displayed a strong united front to others both within the organisation and externally. The CEO said they worked together in a positive manner, benefiting from their respective experiences.

There was strong evidence of collegiate trust board behaviours. NEDs saw themselves as a unitary board with equal challenge and exchange and support. They had been involved in decisions regarding the new executive team structure and were comfortable with how it had evolved. NEDs had roles as chairs on the various assurance committees and they felt the quality of papers presented was very good, although papers were occasionally late. There was an opportunity to agree escalation and reflective review at the end of each meeting.

There was strong non-executive input into financial sustainability and efficiency matters, with assurance provided by "deep dive" information requests from committees and the board for example, into reason for the overspend by 111 service in north east London. Processes for identifying and managing financial risk were well understood by the board. The board had a track record of ensuring financial control totals were delivered.

The trust management team had changed to reflect the shift towards the "system integrator" role. Financial leadership was having to adapt to have different horizon scanning capabilities and relationships.

The finance department has been restructured to ensure that it had appropriate capacity and capability to deliver its objectives. Through her restructure, the chief financial officer (CFO) had sought to strengthen financial control; the procurement function; and commercial focus to respond to the changing demands on the service.

The trust had strengthened leadership at other levels within the organisation. The trust had introduced the senior clinical leadership role to improve clinical focus in operational sectors. These senior leaders worked with the ADO's to improve clinical delivery. The trust had introduced rotational paramedics to improve recruitment and retention and make the NHS Constitution a reality through supporting efficient use of resources, making sure patients got better care. The role ensured right level of care through supporting staff dealing with the high volume of calls to falls, frailty and mental health patients. The trust had increased the number of advanced paramedic practitioners for Urgent Care and these advanced paramedics had reduced conveyance of patients with lower acuity calls. All five Sustainability and Transformation Partnership STP areas have now got them.

The medical director told us that having consultant paramedics on various governance groups helped in hearing the voice of clinical services, and she didn't feel her position was isolated in terms of the board. The board was strengthened by having two non-executive directors with clinical background too, and there was helpful challenge from board members.

Members of the executive team reflected on the leadership with comments such as, 'I love being part of a team who I learn from on a daily basis.' The work and contributions of the outgoing director of operations was specifically commented upon. They were described as 'a credit to the organisation.'

The trust was adapting its leadership culture and seeking to improve services within funds available. Given the difficulties in agreeing the contract, and the implementation of the financial recovery plan, the chief financial officer (CFO) had advised the board that quality improvements could not be delivered without additional funding. However, she told us that she was not countenancing deterioration in quality standards.

We were given examples related to improvements in the safeguarding infrastructure which had been supported by the executives and board. This included being able to increase the safeguarding team capacity from six people to 12. As a result, the team had been strengthened since our previous inspection and this had enabled multiple activities to be supported and achieved.

The trust pharmacist led on medicines optimisation for the trust. They were line managed and professionally accountable to the medical director, to allow communication directly to the board.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and most staff in core service areas spoken with understood and knew how they contributed to the achievement of the trust's vision and strategy.

The London Ambulance Service NHS Trust's organisational strategy was signed off by Trust Board in May 2018. The strategy was presented at the public board and an update was given at the May 2019 meeting. NEDs told us how they had worked as a united board to develop the future strategy.

We reviewed the trust's strategy 2018/19-2022/ 2023 titled 'A world class ambulance service for a world class city.' The strategy set out the trust's vision and three key themes, with four goals to be achieved including:

Providing outstanding care for all patients.

To be a first-class employer, valuing and developing the skills, diversity and quality of life of our people.

Provide the best possible value for the tax paying public, who pay for what we do.

Partner with the wider public sector and NHS to optimise healthcare and emergency services provision across London.

The trust had acknowledged within its strategy the need to deliver fundamental changes to its organisation's culture, capabilities and infrastructure in order to deliver the long-term plan for success. Information provided clear details on what it wanted to achieve and how it proposed to succeed, the number of dependencies with commissioners, partners and national bodies, and the measures of success.

The trust board has a clear vision to move its role and objectives to facilitate system integration rather than conveyance of patients. It reviewed its risk appetite regularly and was not afraid to change the balance of financial safety and risk. It had confirmed its risk appetite at its meeting of 24 September 2019. The trust board was aware of the need to align its workforce strategies to meet the need of its changed operating models to reduce the risks to business plan delivery. It

perceived that a significant risk was the lack of development of commissioning competence in its lead commissioner to reflect the changes in the business model.

Additional strategies had been developed by the various executive leads and their respective teams, with the aim of supporting the trust's overarching strategy. We reviewed a number of these and summarise some of their points here.

At our previous inspection we had considered the trust's People and Organisation Development Strategy 2017-2020, which had described seven strategic themes; Talent; engagement; healthy workplace; performance development and growth; leadership and management, inclusion and rewarding and recognising excellence. The strategy had been revised in light of the trust's new strategy, and was now titled the People and Culture Strategy, covering the period 2018-2023. We noted the achievements made against the previous strategy, which included by way of examples:

Completed recruitment to the executive leadership team.

Worked with staff and other stakeholders to develop a new vision and behaviours aligned to values.

Improved understanding of health, safety and wellbeing responsibilities.

Implemented Freedom to Speak Up policy with a new role to support staff in raising concerns.

Implemented MyESR across the London Ambulance with over 98% of staff now able to update their own employee record and complete eLearning via mobile devices.

Designed and implemented an ESR Workforce Dashboard, enabling our managers to access key workforce information about their teams and staff and ensuring the trust has far greater understanding and assurance of StatMan training and appraisal compliance.

Launched the Management Development Programme with the start of the Visible Leader Programme.

Completed organisational restructures across all directorates except Strategic Assets and Property.

The revised strategy set out the broad aims and objectives under several key areas, these being:

Talent, development and growth

Engagement and recognition

Leadership, management and performance

Inclusion

Healthy workplace

The main challenges had been identified, along with priorities and statements of commitment were described at various levels, as were the specific actions to be taken with timeframes and the individual with responsibility. The measures of success were indicated as being via the staff survey, monthly performance monitoring, meetings and internal communications channels including, trade union partnership meetings, the Learning into Action Facebook group, and executive roadshows. Feedback from regulators and auditors would be used to confirm that people related risks were being reduced.

A detailed scorecard for People and Culture had been in use since the previous inspection and was monitored by the Executive Leadership Team and the Board. The scorecard tracked performance against 49 indicators (31 monthly, three quarterly, 15 annually), covering all five themes. Further, the strategy was to be monitored through the People and Culture Committee

reporting to the Executive Leadership Team, People and Culture Committee and Board on specific projects.

Our discussion with the director of people and culture confirmed the trust's strategic intent and the main areas of focus, which included staffing and engagement. They were aware of the importance of getting the basics right and that elements of the strategy required the application of practicalities. To this end there had been improvements in processes, such as a more systematic approach to recruitment, with evaluation of the processes, a review of diversity and exit interviews for example. The latter was helping the trust to identify themes around leavers.

The trust had a clinical strategy which covered the periods 2016/17-2022/23 and had been refreshed in 2019. We viewed the amended and updated draft report as provided to the Quality Assurance Committee in September 2019. Committee members challenged the trust around the length and content of this, some of which they felt was more operational. They also felt the STP's did not come though strongly enough. The revised clinical strategy was subsequently signed off at the board meeting held on 24 September 2019.

We saw that the aims of the trust's medicines optimisation five-year work plan included improving medicines management reporting, work use medicines as safely as possible including optimal use of antimicrobials and scope then pilot the roll of non-medical prescribing paramedics. Whilst also continuing the safe used of medicines within the integrated urgent care clinical assessment service.

Learning Disability Strategy 2019 – Including Learning Disability Improvement Standards for NHS Trusts. This set out several key areas of focus including:

Learning Disability Improvement Standards for NHS Trusts

Recruitment processes

Education and training

Supportive materials

Website

These were further described in terms of the current position of LAS and what was expected. There were four actions with nominated leads set out for 2019/20.

The LAS Mental Capacity Act (MCA) Strategy 2019-21 set out the statement that the trust would have a corporate MCA lead and a Clinical MCA lead and the responsibilities of individuals and staff groups. We noted the actions to be taken, which included proposed training: Health Education England and College of Paramedics MCA level 3 e-learning within the core skills refresher programme. Hear and treat staff to undertake (level 2 Safeguarding). Designated staff to complete the MCA level 1 e learning, and clinical staff undertake two hours face to face training on Application of the MCA and completion of LA5 with appropriate evidence.

It was also proposed that the Good Practice Guide - recording consent, mental capacity and best interest's decisions in healthcare settings be added to the IPAD's so staff had access to the relevant information. Monitoring of this was via leader spot checks on MCA compliance and report via the Safeguarding Assurance Group.

We noted the safeguarding 2019/20 work plan identified six key areas of focus as follows:

- Excellent governance and assurance of the trusts safeguarding processes and compliance.
- Development of the safeguarding team.

- Successful delivery of safeguarding training plan, local education and supervision.
- Safeguarding innovation and review current practices to identify cost savings.
- Ensure integration of 111 & IUC.
- Forge effective relationships internally and externally to safeguarding children and adults.

At our last inspection we had questions whether enough attention was being given to IT and to the estate and resources strategies, which were not fully addressed in the responses. On this inspection visit we found there was a much clearer level of detail for both these areas.

The trust's Digital Strategy 2018/19 - 2022/23, which was presented at the March 2019 public board was provided to us. The strategy noted that the current digital services and basic IT, like much of the NHS, was far behind where it needed to be. Despite this, the trust recognised it was in a unique position to have a lead role in developing the systems to support optimum urgent and emergency care.

Three of the trust's strategic themes depended on having an appropriate and well-developed digital and technological system, these were:

Comprehensive urgent and emergency care coordination, access, triage and treatment, with multichannel access for patients.

A world class urgent and emergency response with enhanced treatment at scene and for critically ill patients a faster conveyance to hospital.

Collaborating with NHS, emergency services and London system partners to provide more consistent, efficient and equitable services to Londoners.

A fourth element had also been described in the strategy as: Sustainable and effective corporate functions. The trust had also identified seven pillars required to enable the delivery of the strategic aims. For example; digitising the patient journey; connecting clinicians and clinical data, build an advanced data and analytics capability, and transform the employee experience. Actions were stated within target periods, along with the governance and oversight of the delivery, which was via the Logistics & Infrastructure board committee. A programme board structure had taken place, with cross-trust representation reporting into the trust-wide Board. We noted the costs associated with these plans had been identified but did not at this stage take into account any efficiencies that may be made.

The LAS Estates Vision was presented to the public board on 24 September 2019 and had been signed off by the board. Reference was made to the work which had begun in 2018 on estates and the current position of the whole of the trust's estate, and how they might look to change in the future. The information therein set out the objectives and linked with the trust's strategy for 2018-2023, supported by a case for change and proposed next steps.

The trust reported on its cost improvement plan and updated the board through the Finance and Investment Committee. We reviewed the Efficiency Assurance Update for May 2019, which provided oversight of progress and risks and mitigations and service development.

We were present at the annual general meeting during which a presentation of the trust's financial position was shared, along with the quality report.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients

receiving care. The trust promoted equality and diversity in daily work and provided opportunities for career development. They recognised these areas required continuous focus to improve staff experiences. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff Diversity

The trust provided the following breakdowns of staff groups by ethnicity below:

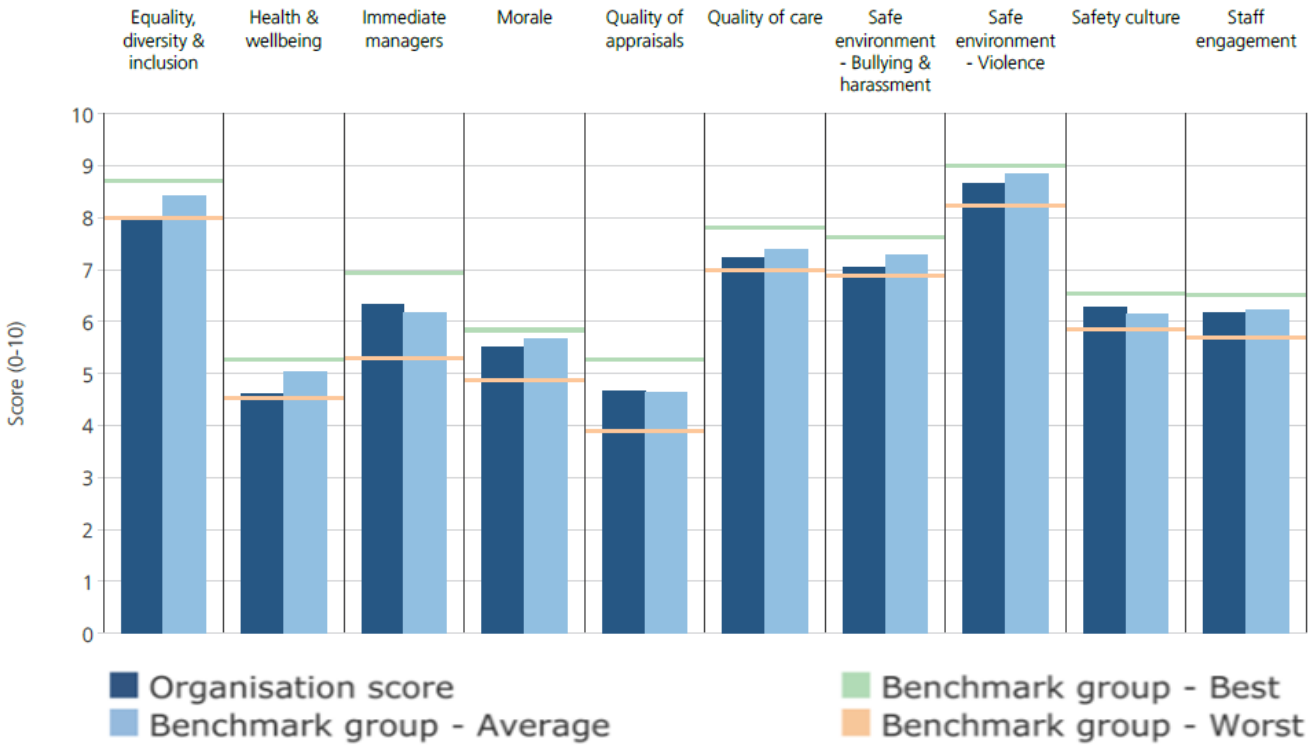
Ethnic group	Qualified ambulance service staff (%)	Qualified nursing and health visiting staff (%)	Support to ambulance service staff (%)	NHS infrastructure support staff (%)
White	52.8%	0.3%	18.7%	0.85%
Mixed	1.6%	0.0%	1.2%	0.4%
Asian	1.2%	0.0%	1.7%	1.4%
Black	1.3%	0.1%	3.2%	0.2%
Chinese	0.2%	0.0%	0.0%	0.1%
Other	0.4%	0.0%	0.2%	0.1%
Unknown / Not stated	0.9%	0.1%	0.2%	0.1%

(Source: Trust Provider Information Request – Diversity)

The executive team were proud of the improvement in the staff survey results and the rise in respondents. There was recognition that the culture was changing and that openness, sharing information and bringing matters to managers attention had improved. The medical director reported that the freedom to speak up had been an enabler of this.

NHS Staff Survey 2018 results – Summary scores

The following illustration shows how this provider compares with other similar providers on ten key themes from the survey. Possible scores range from one to ten – a higher score indicates a better result.



The trust's 2018 scores for the following themes were significantly higher (better) when compared to the 2017 survey:

- Equality, diversity & inclusion
- Immediate managers
- Safety culture
- Staff engagement

There were no themes where the trust's scores were significantly lower (worse) when compared to the 2017 staff survey.

(Source: NHS Staff Survey 2018)

Workforce race equality standard

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts have to show progress against nine measures of equality in the workforce.

The scores presented below are indicators relating to the comparative experiences of White, Black Asian and minority ethnic (BME) staff, as required for the Workforce Race Equality Standard.

WRES indicators from Electronic Staff Records (ESR)

The data for indicators one to four and indicator nine is supplied to CQC by NHS England, based on data from the Electronic Staff Record (ESR) or supplied by trusts to the NHS England WRES team, while indicators five to eight are included in the NHS Staff Survey.

Notes relating to the scores:

- These scores are un-weighted, or not adjusted.

- There are nine WRES metrics which we display as 10 indicators. However, not all indicators are available for all trusts; for example, if the trust has less than 11 responses for a staff survey question, then the score would not be published.
- Note that the questions are not all oriented the same way: for 1a, 1b, 2, 4 and 7, a higher percentage is better while for indicators 3, 5, 6 and 8 a higher percentage is worse.
- The presence of a statistically significant difference between the experiences of BAME and White staff may be caused by a variety of factors. Whether such differences are of regulatory significance will depend on individual trusts' circumstances.

WRES Indicators from ESR (HR data) (*)	BME Staff	White Staff	Are there statistically significant difference between...	
			BME and White staff?	Last year and this year? (BME staff) (***)
1a. Proportion of clinical staff in senior roles, band 8a+	0.0%	0.2%	●	-0.3% →
1b. Proportion of non-clinical staff in senior roles, band 8+	4.8%	13.9%	●	0.0% →
2. Proportions of shortlisted staff being appointed to positions	8.4%	15.3%	●	-6.4% ↓
3. Proportion of staff entering formal disciplinary processes	5.3%	2.6%	●	1.3% →
4. Proportion of staff accessing non-mandatory training and CPD	2.8%	5.0%	Not assessed	

Key

- ● Statistically significant or negative finding
- ● Not statistically significant
- ● Positive finding
- ○ Statistical analysis not undertaken as less than 30 BME staff responded
- ↑ Statistically significant improvement
- → No statistically significant change
- ↓ Statistically significant deterioration

In the 2018 NHS staff survey report, three of the ESR staffing indicators shown above (indicators 1a to 4), showed a statistically significant difference in scores between White and BME staff.

- In 2018, BAME candidates were significantly less likely than white candidates to hold senior (band 8+) non-clinical roles (4.8% of BME staff compared to 13.9% of White staff). This score was not significant different compared to the previous year, 2017.

- In 2018, BAME candidates were significantly less likely than White candidates to get jobs for which they had been shortlisted (8.4% of BME staff compared to 15.3% of White staff). This score showed a significant decreased by 6.4% compared to the previous year, 2017.

- In 2018, BAME staff were significantly less likely than White staff to be disciplined (2.6% of BAME staff compared to 5.3% of White staff). This score was not significantly different compared to the previous year, 2017. The indicator looks at the relative likelihood of staff entering the formal disciplinary process, as measured by the start of a formal disciplinary investigation.

WRES indicators from NHS staff survey

WRES Indicators from the NHS staff survey (**)		Proportion of respondents answering "Yes"			Are there statistically significant differences between…		
		BME staff	White staff	All staff	BME and white staff?	This trust and its peer group?	Last year and this year? (BME)
5. Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	Trust	42.5%	58.1%	51.6%	●	●	3.6% →
	Peer group	39.8%	48.3%	47.4%			
6. Staff experiencing harassment, bullying or abuse from staff in the last 12 months	Trust	31.6%	27.9%	28.7%	○	●	-6.1% →
	Peer group	30.7%	28.0%	28.1%			
7. Staff believing that the trust provides equal opportunities for career progression or promotion	Trust	51.2%	68.2%	65.0%	●	●	4.1% →
	Peer group	55.9%	71.4%	69.7%			
8. Staff experiencing discrimination at work from a manager / team leader or other colleague?	Trust	17.4%	9.5%	10.7%	●	○	-1.7% →
	Peer group	17.1%	10.5%	11.0%			

Key

- ● Statistically significant or negative finding
- ○ Not statistically significant
- ● Positive finding
- ○ Statistical analysis not undertaken as less than 30 BME staff responded
- ↑ Statistically significant improvement
- → No statistically significant change
- ↓ Statistically significant deterioration

Of the four indicators from the NHS staff survey 2018 shown above (indicator 5 to 8), the following indicators showed a statistically significant difference in score between White and BAME staff:

- 42.5% of BAME staff experienced harassment, bullying or abuse from patients, relatives, and the public in the past year (2018 NHS staff survey) which was significantly lower when compared to 58.1% of White staff. This score was not significantly different compared to the previous year, 2017.

- 51.2% of BAME staff believed that the trust provided equal opportunities for career progression and promotion (2018 NHS staff survey) which was significantly lower when compared to 68.2% of White staff. The score was not significantly different compared to the previous year, 2017.

- 17.4% of BAME staff experienced discrimination from a colleague or manager in the past year (2018 NHS staff survey) which was significantly higher when compared to 9.5% of White staff. This score was not significantly different compared to the previous year, 2017.

There had not been any BAME voting board members at the trust, which was significantly different to the number expected, based on the overall percentage of BAME staff at the time of the last survey. However, changes to the voting board membership more recently showed this was no longer the case.

(Source: NHS Staff Survey 2018; NHS England)

The trust's Workforce Race Equality Standard Action plan for September 2018 to August 2019 was presented to the board.

We were told of the ambitions to properly reflect London as a whole in staff recruitment. This needed a system-wide approach and was very much dependent on working with universities to increase the numbers of BAME applicants entering paramedic study. The recruitment processes

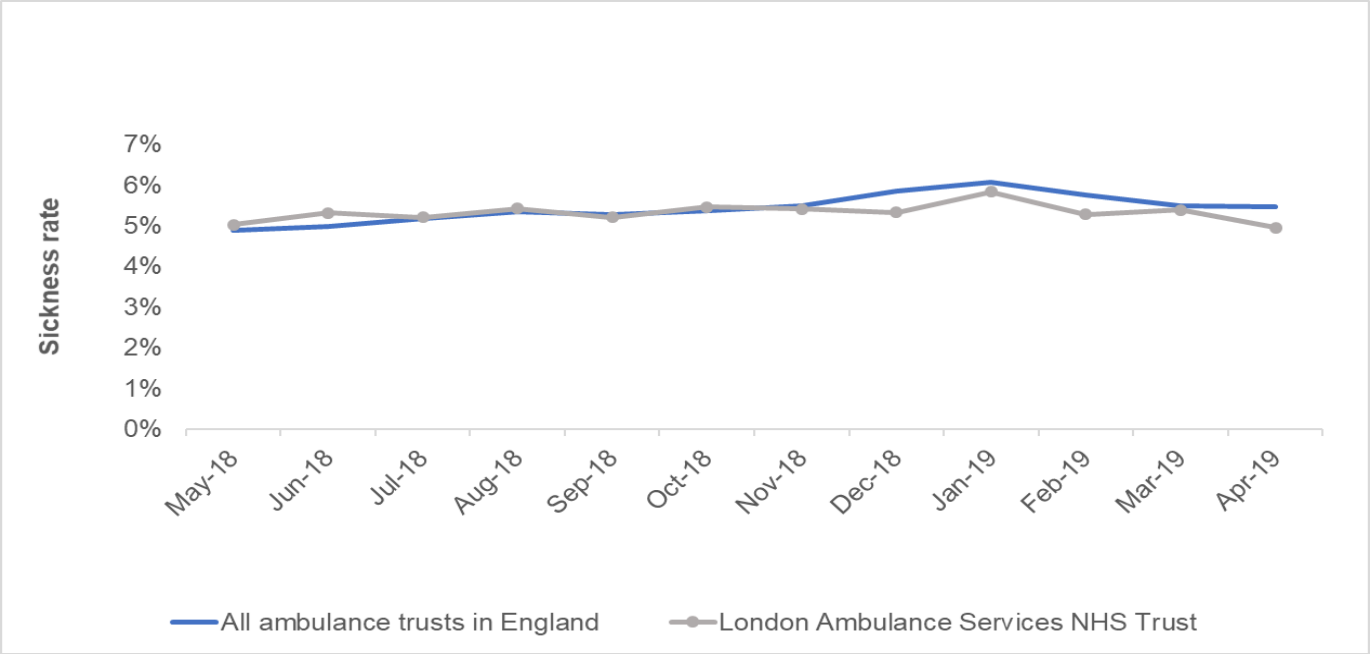
had been looked at for Emergency and Urgent Care and EOC, targeting BAME areas. Reverse mentoring, which started at executive level had continued to be used too.

Friends and Family test

From December 2017 to May 2019 the trust had a low response rate with eight or less responses per month. Due to the small numbers we were unable to complete any meaningful analysis.

Sickness absence rates

The trust's overall sickness absence levels were similar to the ambulance trust average from May 2018 to April 2019.



(Source: NHS Digital)

The chief quality officer told us they were very proud of the people and staff working at the trust and in particular the work of the pioneering services around end of life care, maternity and the mental health activities. They were very aware of the continuing cultural issues in a relatively small part of the service which suggested a blame culture. A new associate director had been put in place in one regional area to try and address this further.

There was recognition by members of the executive team that there had been an anti-management view from some front-line staff, which they had worked to address over the past few years. Work had included talent management and the development of a matrix which showed staff progression based on what they wanted for themselves. They reported that staff were much more engaged but there was still work to be done.

The medical director told us about the progress made in the Emergency Operations Centre (EOC) since 2017. There had been a focus on psychological welfare, recognising the young workforce and their exposure to situations which may impact later. In the leadership work they had explored how line managers could recognise changes in staff and undertook a campaign called 'are you ok?' Techniques to aid discussion had been covered, recognising it could be difficult to deal with issues when the staff were not always working with the same managers.

It was felt by the medical director that the restructuring and reorganisation of the executive offices to an open plan arrangement had broken down some of the barriers. They fully acknowledged that there was work still to do to improve the support to EOC staff. This included a review of the annual leave policy, which in its current format was making it difficult to flex and manage the rotas as well as they could be.

They also acknowledged that the rapid transfer of the north east London 111 service as part of the trusts integrated urgent care (IUC) services had happened in a way which meant some of the necessary staff were not immediately available to support the service delivery. Embedding a remote service as this took longer than expected and it had taken longer to make the team feel part of the organisation. As a result, more support and peer review was needed. The management team had taken on the feedback and were working to address this.

The director of people and culture told us staff knew it was safe to challenge and they had tried to encourage a change in language across staff groups, including within the Emergency Operations Centres. The visibility of the freedom to speak up guardian, who attended chief executive roadshows raised the profile of speaking up to staff. The trust had dedicated dignity at work champions and an electronic records tracker enabled the executive team to see clearly the number of grievances and complaints raised by staff, although not by whom.

Most staff in the core service inspection areas were aware of the incident reporting process, although there were a small number of staff in EOC who were not as aware or engaged in the process. There was still a dependence on staff reporting matters, despite the trust continuing to emphasise the importance and value of doing so. We saw where incidents were raised there was a strong process for dealing with these, as was the case at the last inspection. The trust continued to apply duty of candour principles appropriately. We were able to see evidence of this in documentation reviewed as well as in meetings attended prior to inspection.

Freedom to speak up was very well developed across the trust. The freedom to speak up guardian (FtSUG) had been in the substantive post since July 2018, initially in a part time role but increased to full time in December 2018 after it was recognised the role was more demanding of their time. Since then they had the assistance of a part time coordinator. The trust also had 32 freedom to speak up advocates from different areas within the organisation, 26 of whom had been trained fully, with others to follow. Sixteen hours of time was given to each of the advocates for their responsibilities.

The FtSUG reflected on their role and the level of support they got from their line manager, the chief executive (CEO) and NED. All of whom were described positively in terms of their commitment and the value of this area. We were told by the FtSUG they also had a good support network, with external supervision and an opportunity to meet with others in the role for a whole day once a year. They participated in the National Ambulance Network for Guardians and had a buddy in the east of England.

There had been 67 speak up matters raised in the last quarter, and 121 so far in the financial year. Formal reporting to the board was in person by the FtSUG. They wrote their own report, which we reviewed and was noted to be an exemplar in its content and structure. They also met the CEO monthly and with staff's permission, shared some stories which helped to connect him to the front-line experiences. There had been challenged around the speed at which speak up issues were closed down and the FtSUG had since set a target of 60 days for this. More recently the FtSUG had been invited to attend the senior leadership meetings, which they felt was a very positive action.

The FtSUG said there had been a change in the culture of the organisation, although there remained some areas of cynicism, things were not perfect, but it was improving. The main themes arising from staff related to confidentiality, bullying and harassment between peers, difficult relationships with line managers and lack of communication, and some issues were about estates and maintenance.

The trust advised us they had been recognised with an award for its 18 percentage point FTSU Index, which was the most improved Freedom to Speak Up Index of any trust in England

We reviewed the freedom to speak up: raising concerns (whistleblowing) policy, which was updated and ratified in March 2019. This made it clear the policy did not apply for people who wished to express concerns about their employment that affected only them and directed staff to the grievance policy or dignity at work policy. The raising concerns (whistleblowing) policy provided information and guidance, including links to other information and support.

Trust objectives and those within the medicines optimisation five year work plan formed the basis of the medicine's teams' objectives. These were monitored through the medicine's management group, regular one to one's and annual appraisals.

The medicines management group reviewed medicines incidents and near misses. These were summarised and shared with staff via newsletters or clinical briefings.

The trust launched a new e-learning module in August 2019; ' The civility and behaviours e-learning package', which had been trialled in the north east sector. This focused on using communication as a way to resolve conflict and to develop an understanding around different behaviours.

Staff support services were available to staff and we saw there was a leaflet which could be downloaded. Information was also available to staff on matters such as: childcare, benevolent fund, dignity at work, occupational health, LINK, (The listening, informal, non-judgmental, confidential, a voluntary network available to all which provides trained members of staff to listen and support colleagues), and wellbeing and stress management.

Staff had access to 'Trauma Risk Management' (TRiM). This included two consultations, one 72 hours after the incident and one-month follow up to monitor progress and to identify if trauma therapy was needed. The trust had a major incident trauma information pack (MiTip). Additionally, there was access to a counselling service via a telephone, email or in an emergency.

Governance

The majority of leaders operated effective governance processes, throughout the service and with partner organisations. There was a lack of awareness of some EOC managers about the reporting lines where incidents crossed over service areas. Staff at all levels were in the main clear about their roles and accountabilities and had opportunities to meet, discuss and learn from the performance of the service.

The executive group and quality governance structure had been clearly defined. There were 23 operational groups and committees, 22 of which fed into the Quality Oversight Group and had a dotted line to the Quality Assurance Committee then upwards into Trust Board. This included by way of examples:

- Infection Prevention & Control Committee
- Patient Safety and Clinical Effectiveness Group
- Mortality and Morbidity Group

- Clinical Audit & Research Group
- Clinical Education Working Group
- Clinical Practice Working Group
- Medicines and Equipment Oversight Group
- Serious Incident Assurance and Learning Group
- Mental Health Group (including MCA & MHA)
- End of Life Care Group
- Safeguarding Assurance Group

There were embedded processes and procedures underpinning the identification and management of financial risk. The head of internal audit had given the board substantial assurance about the operation of internal controls in the trust for 2018-19.

We saw the Information Governance Group and Risk and Compliance and Assurance Group fed into the Audit Committee, Executive Group and up to the Trust Board. Beneath the various groups and committees were Sector Governance Groups. The medical director informed us the governance processes were much clearer from the board to the local stations and because of this they were much more able to triangulate quality and safety against operational performance.

The agenda for the Quality Oversight Group meeting of August 2019 showed that a range of information was prepared and presented, including for example: Quality reports for sectors, the Quality Strategy Bi-Annual Update, risk management plans and the revised governance structure.

We heard a presentation by the Patient Safety and Clinical Effectiveness Group on the learning from deaths proposed process. This demonstrated a sound and well thought out approach to the required trust actions in light of the national guidance for ambulance trusts on learning from deaths and its framework to support ambulance trusts in England to learn from deaths in their care.

The section on Serious Incident Assurance and Feedback Group covered a thematic review of serious incidents, as well as a key issues report. We saw too that infection prevention and control (IPC), safeguarding and medicines were covered.

The north east London and south east London Integrated urgent care (IUC) Quality Governance and Risk Group was accountable to the Quality Oversight Group, and issues requiring support and escalation were raised via a key issues report into the Trust Quality Oversight Group. We saw for example, escalated issues around the number of Incidents awaiting quality check before closure from the central team had increased and concerns raised regarding ‘dropped’ calls. The latter of which resulted in a level two root-cause analysis (RCA) being commissioned.

The IUC’s and EOC now had their own quality report which followed the same framework as the main one and was integrated. The chief quality officer had developed with one of the QGAMs a detailed quality assurance framework for IUC. This reflected all the learning from mobilisation and incidents as well as standard assurance KPIs. We were shown a copy of this document and noted it was detailed in content regarding clinical quality and governance, operational governance and risks. Responsibilities were defined at the first line, along with second line monitoring and third line internal independent monitoring.

The quality governance structure within IUC was now reflective of the emergency operations structure. A head of quality governance and assurance who would work across 999 and IUC was to be recruited in October. This was planned to ensure cross working and integration and reflected the overarching trust integration strategy.

Medicines incidents were reported through an electronic recording system. The trust pharmacist was supported by a paramedic who was the trust's Medication Safety Officer (MSO). The MSO role was a mandatory requirement for all large NHS Trusts following the Francis report and NHSE alert (2014) which stipulated this. The trust had an MSO since this time, up until March 2017 this was a paramedic, then from March 2017 to March 2019 this was the trust pharmacist. Then upon expansion of the team – the MSO role was given to a paramedic.
The MSO automatically received and reviewed notifications of medicine incidents. A multidisciplinary team at the MMG reviewed these incidents.

The Medicines Management Group (MMG) monitored the medicines optimisation within the trust and reported to the quality oversight group. The trust quality outcomes group received an annual update on medicines optimisation from the MMG.

Assurance of infection prevention and control (IPC) processes were presented and monitored by the Infection, Prevention and Control Committee (IPCC). The medical director held the role of Director of Infection Prevention & Control (DIPC), reporting directly to the Board on IPC performance throughout the year. The IPCC met quarterly and was chaired by the DIPC. The IPCC was a subcommittee of the Quality Oversight Group (QOG); which was a subcommittee of the Quality Assurance Committee (QAC), reporting directly to the Trust Board.

The Infection Control & Decontamination group (ICDG) was a sub- group of the IPCC. As an operational group, they met quarterly, at least two-weeks prior to the IPCC. The meeting was chaired by the Head of IPC. The function of the ICDG was to promote best practice by raising and discussing IPC issues as they arose, in operational detail. Issues requiring executive decisions were escalated to the IPCC.

The trust's Safeguarding Assurance Group (SAG) met quarterly to monitor safeguarding activity and provide assurance on safeguarding practice. There was SAG sub group called the Safeguarding Operational Group (SOG), which local safeguarding leads, Non-Emergency Transport Service (NETs), EBS manager and NHS 111 attended. They provided assurance on safeguarding activity and provided two way communication of safeguarding compliance and partnership engagement.

SAG reported to the Quality Oversight Group (QOG) bi-monthly providing assurance and raising issues for escalation to Quality Assurance Committee (QAC). This was the trust's assurance committee that fed into the Trust Board. QAC was chaired by a non-executive director.

Safeguarding information was reported to commissioners via the Brent Clinical Commissioning Group (CCG). The Clinical Quality Review Group provided deep dive information on safeguarding practice in the LAS. Members of the safeguarding team attended the following committees; Serious Incident Group, Serious Incident Learning and Review Group, Mental Health Group, Patient Experiences Group, Patient Safety & Effectiveness Group, and the Mortality and Morbidity Review Group.

We found from our review of board papers that these were of a very good standard, with particular reference to the quality of the assurance report. We asked for an example where the papers presented led to a better board decision and were told of some issues around agency spend in the more recently acquired integrated service. This enabled a focus on the financial recovery plan in parallel with patient safety.

Health and safety was monitored and reported via the Corporate Health and Safety Committee. We noted discussion had included the ongoing immunisation status of front line staff. We were told there had been some engagement with the unions around this and there was a commitment on their part to encourage staff to have their vaccinations.

We noted information and heard in the trust presentation to us about the work being done to address the amount of sickness taken as a result of musculo-skeletal injuries, with an emphasis on manual handling practices.

The executive team were very aware of the level of violence and abuse the staff in some areas were subjected to. Supportive mechanisms were in place for staff and these were made clear through the various communications.

The trust had worked in a proactive manner with CQC where information needed to be shared, investigated or responded to. There was an open and transparent relationship, which afforded good working relationships.

Board assurance Framework

The trust provided their board assurance framework (BAF), which detailed four strategic objectives, associated deliverables and accompanying risks. A summary of the strategic objectives is outlined below:

1. To Provide outstanding care for patients
2. To be a first-class employer, valuing and developing the skills, diversity, and quality of life for staff
3. Partner with the wider NHS and public sector to optimise healthcare and emergency services provision across London
4. Provide the best possible value for the tax paying public.

(Source: Trust Board Assurance Framework – May 2019)

We attended the meeting of the Audit Committee on 5 September 2019, which was chaired by a non-executive director. Other attendees included members of the executive and non-executive team, the risk and audit manager and both internal and external auditors.

Papers had been circulated in advance of the meeting in addition to previous minutes and the action log, the latter two of which were fully considered. The BAF was discussed in context of the trust's risk register, with five top risks being highlighted. Risks were described along with a risk owner and the scrutinising committee. Discussion of the BAF was open and reflective, with committee members providing challenge and scrutiny of not just the five top risks but other risks not included on the BAF.

We found the BAF provided a visual 'heat map' which clearly presented the significance of the 5 strategic risks. The report was framed within a clear and explicit statement regarding the organisations' appetite for risk, with clear ranges of acceptable risk identified for each risk. Each risk was linked to specific strategic objectives and agreed deliverables for each objective. Detailed existing controls, further actions, by whom, when and RAG ratings provided on a page for each risk. The BAF was concise, focused, separate and complementary to the organisations Corporate Risk Register.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Finances Overview

Financial metrics	Historical data		Projections	
	Previous Financial Year (April 2016 to March 2017)	**Last Financial Year (April 2017 to March 2018)**	**This Financial Year (April 2018 to March 2019)**	**Next Financial Year (April 2019 to March 2020)**
Income	£355.5m	£364.6m	£389.8m	£416.8m
Surplus (deficit)	£5.9m	£5.7m	£6.6m	£0.0m
Full Costs	£349.5	£358.9m	£383.2m	£416.8m
Budget (or budget deficit)				

The surplus reported in April 2017 to May 2018 was lower than the previous year. Projections for April 2018 to March 2019 indicated that the surplus will decrease. Projections for the next financial year, April 2019 to March 2020, showed that no surplus or deficit is expected.

(Source: Trust Provider Information Request – Finances Overview)

The trust reviewed its risk appetite annually, most recently at the board meeting of 24 September 2019. The trust had a track record of delivering its annual financial control total. There was recognition that the implementation of new services presented risks for both the trust and its commissioners. As a demand-led service, user perceptions of increased effectiveness may bring increases in demand. The trust was working through these risks and how they planned for (horizon scanning) and mitigated.

Risk Register

The trust provided a document detailing their eight highest profile risks. At the time of reporting in May 2019, each of these had a current risk score of 10 or higher (out of 25).

Date risk opened	ID	Description	Risk score (current)	Risk level (target)	Last review date
January 2019	BAF risk no 53	There is a risk that the normal business continuity arrangements followed by the trust will need to be enhanced in case of a no deal departure from the EU due to the unknown nature and extent of the potential disruption to business.	16	8	May 2019
March 2019	BAF risk no 55	The preferred trust strategy may not be deliverable within the trust's timeframe due to the scale of investment, resource required and current system contracting arrangements.	16	12	May 2019
October 2018	BAF risk no 52	There is a risk that the trust will not achieve the required financial targets through the inability to secure additional funding from commissioners in 2018/19 and beyond to fund the delivery of national performance standards.	16	8	May 2019
May 2019	BAF risk no 57	There is a risk that the trust will not achieve the required financial targets through the inability to secure additional funding required from commissioners in 2019/20 and beyond to fund the delivery of national performance standards.	16	8	N/A
June 2017	BAF risk no 45	A cyber-attack could materially disrupt the trust's ability to operate for a prolonged period.	15	10	May 2019
March 2019	BAF risk no 54	There is a risk that the trust will not be able to meet KPI's within our 111/IUC contracts as a result of challenged specialist resource requirements and performance which may result in the trust not fully delivering its strategy.	12	8	May 2019
May 2019	BAF risk no 56	The trust's ability to recruit and retain registered clinicians to the core front line operations will be affected by the changing landscape of the NHS which opens opportunities for paramedics to be employed in other healthcare	12	8	N/A

		settings. This will impact the ability to meet operational targets.			
February 2018	BAF risk no 50	Current UPS capacity is insufficient to meet building supply and demand. Equipment conditions are deteriorating and require upgrade and repair. Failure of the equipment in normal operation or during a network power outage would cause a service failure. Interruption of electrical supply would impact IM&T data and telephony services. This will interrupt EOC services at Bow until repairs are undertaken.	10	5	May 2019

(Source: Board assurance framework)

The trust's risk management strategy and policy, January 2018 was reviewed. This set out key messages to all staff around the identification of all clinical and non-clinical risks to the delivery of safe, effective and high quality services. A strategic statement provided the overarching principles and a framework and process to support staff to manage risks and how this was integral to everyday management practices. There was an electronic IT system which formed the trust's integrated risk report.

Risk management training was defined within the policy and ranged from level 1-foundation through intermediate, level 2 to level 3, advanced. The expectation was that risk registers be identified and held at station/local/sector level.

The risk register was discussed within the meeting of the Audit Committee, which we attended on 5 September 2019. It was noted in the papers circulated prior to this meeting that risks had been discussed by the trust board on the 30 July 2019, via the Risk, Compliance and Assurance Group and Executive Committee.

Our review of the risk register indicated that there were five key goals linked to the trust's '4 Ps' strategy. The risk appetite and score for each of these was stated for the risk category. The categories were:

- Quality outcomes linked to patients.
- Reputation linked to partners and the public.
- Innovation linked to partners and the trusts people.
- Financial, linked to partners and the public.
- Compliance, linked to partners and the trust's people.

Goals and deliverables were clearly stated, along with a review against the CQC key lines of enquiry (KLOE's) where relevant, and risks. Information around further mitigations was stated.

The corporate risk register had two current red rated risks, one related to estates and the other to fleet and logistics. Controls in place were stated, along with the risk owner, last review date, current level of risk and target risk level. We noted the assurance, actions taken, and progress updates were included.

The trust made us aware there had been a delay in securing the CCG contract. This was not felt to be a big risk for the trust. The trust had inherited services from the private sector contractors that were, in the trust's terms, unaffordable. The trust was in negotiation with commissioners about managing in-year contract performance risk. We followed this up with NHS England and NHS Improvement and were advised that the LAS contract was always the last to be signed, due to the number of parties involved. They were concerned that there were some issues outstanding six months into the year, and there was intensive work with commissioners and the trust to reach agreement on these. Although they were not concerned about service delivery, it was possible that the outcome may put some financial pressure on the trust. This was expected to be a relatively small amount (compared to the overall size of the contract) and should be manageable.

The finance department was led by an experienced CFO who understood the need to balance clinical care with financial control and delivery. The CFO had obtained £4m to augment capital funding through gaining bonus PSF funding and cash funding at the year end. It did however have a reliance on agency staff, especially in new roles that it had taken on from private sector. It was fully recognised that the competition and pay grade differentials arising from new services and models of care and the trust was implementing horizon scanning and lobbying to mitigate this risk.

In terms of financial governance, risks approaches included the restructuring of finance teams and the NED approaches of clear expectations, benchmarking and challenge. The CFO had implemented a financial recovery plan once unplanned cost pressures emerged. It was expected that these cost pressures would be fully mitigated in-year, allowing the financial control total to be achieved.

There were systems and processes to monitor and report on areas of risk in all areas. We asked about the risks related to recruitment and retention within the Emergency Operations Centre (EOC) and were told by the chief quality officer the staffing rosters were not updated to reflect the structural changes within the area. They had recognised there was a need to ensure risks were identified fully and managed. To this end they had sought an independent consultant review of the rostering, training and education of staff working within EOC.

Risks related to the Integrated Urgent Care centres (IUC), including for example, the availability of specialist clinical resource was monitored and managed under BAF risk 54. Assurance was monitored through a serious incident themed action plan and its progress toward completion. This was overseen by Quality Governance and Assurance Manager (QGAM). The IUC Improvement Plan was managed by the QGAM and this was described in the August 2019 Quality Oversight Group minutes as subject to monitoring twice weekly and reported through the Executive Committee (ExCo) weekly.

Medicines

The trust pharmacist managed medicines related risks, which were recorded on a risk register. The medicines team reviewed national safety alerts relating to medicines. Relevant alerts would be reviewed by MMG and were responsible to monitor the implementation of the alerts.

The chief pharmacist was a member of the London RMOC, therefore ensuring that the prehospital setting was incorporated into any medicine's optimisation plans. Through their attendance at the ambulance pharmacists' network, the trust was aware of their position compared to other NHS ambulance trusts with respect to common concerns.

Infection prevention and control

The Infection, Prevention and Control (IPC) Annual report for 2018-19 was reviewed. It was noted the report had been prepared by an independent IPC specialist consultant, to sustain the strategic position, in the absence of the head of IPC.

Monthly quality and performance reports were submitted by the IPC team for the following three areas: Hand hygiene audits through observed working practices, six-weekly deep cleaning of vehicles and premises cleanliness.

Information in the annual report showed all key performance indicators exceeding trust performance targets. Hand hygiene compliance achieved an overall score of 95.14%, against at 90% target. Vehicle deep clean achieved a 95.2% compliance, with a target of 90%, station cleanliness scored 96% with a target of 90% and mandatory training at levels one and two both exceeded the 90% target, having a score of 94% respectively.

There were seven objectives which were not fully met at the end of the financial year as a result of the lack of IPC presence. These were considered for inclusion into the 2019-20 Annual

work programme. The aims of the 2019-20 IPC work programme were stated, which included; supporting front line clinical staff to deliver the best IPC practices. This would be done through the encouragement of front-line ownership, with strengthening of the IPC champion / link practitioner programme. Audit would be focused on front line practice and the 2019-20 audit programme was expected to introduce clinical ride out observational audits of IPC practices. Data obtained from this audit activity, would then inform the focus for IPC educational materials.

Safeguarding

The trust had an executive director lead for safeguarding chief quality officer. They were responsibility for implementing and monitoring the ongoing assurance of safeguarding within the trust. The chief quality officer was proud to report LAS as being the only ambulance service to provide level three safeguarding training to all front-line staff, not just paramedics.

The head of safeguarding and prevent was the statutory named professional for Safeguarding. They were responsible for ensuring the trust was compliant with legislation and practices in relation to safeguarding and setting the trust's strategic objectives within the organisation.

We noted from the annual safeguarding report that the trust engaged with 64 Safeguarding Boards. The trust supported local Strategy and Rapid Response meetings and provided information to support the work of the Boards, although it was not able to attend every safeguard board meeting. Brent Children and Adult Boards was the trust's lead safeguarding Board, through which practices were scrutinised. Reports and audits provided for scrutiny were available to other boards across London if requested.

The trust reported that they responded to over 5000, 999 calls every day and in 2018/19. Of these they raised safeguarding concerns for an average of 2% of incidents received. In the period reported, the trust saw a 7% increase in safeguarding referrals to 23,471. The trusts 111/ Integrated Urgent Care services in south east and north east London also raised safeguarding referrals and concerns via the trusts reporting process.

There were no open safeguarding risks on the respective risk register. There were two safeguarding related risks open which were held on the Emergency Bed Service (EBS).

The trust's safeguarding team had an annual audit plan 2018/19, which included auditing referrals for the following by way of examples; Child female genital mutilation (FGM), Discriminatory abuse, Patients with a Learning Disability and Safeguarding Concerns, and the referral process. In addition, an internal audit of staffs' knowledge and retention of staff learning. Audit findings, recommendations and actions taken were highlighted in the annual safeguarding report, which we noted to be clearly detailed.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Since the last inspection the trust had continued to build on strengthening information technology and cyber security through the leadership of the chief information officer (they were also the senior information risk owner -SIRO). They told us it was a huge benefit having a NED with a background in IT, and nine months ago they had also appointed a chief clinical information officer who was a paramedic.

The Information Governance Group had been strengthened and they had introduced checks on data quality. Issues were being managed well, although it was recognised there was work to be done on embedding a culture of importance around data security. We were told there was a backlog of some work, which arose as a result of initial difficulties in recruiting to the team.

The trust board received a wide range of performance information in public session. Summary financial information was provided within the chief executive's report and assurance was provided from the reports of the meetings of the Board's Audit and Finance & Investment committees. The board committees tested information provided through testing process; gaining assurance through probing discussion; and applying knowledge and benchmarks gained from other industries and wider experience.

Arrangements between the chief information officer and the Caldicott guardian, who was the medical director, remained unchanged.

At the previous inspection we identified an issue with the accessibility of information, as data collected for patients around equality monitoring was being collected in paper format and was not readily accessible. We reviewed the data quality policy for 2018-2021 and the data quality assurance implementation plan for the same period as part of the current inspection and did not identify any reference to this matter in either. However, the digital strategy fully acknowledged the trust's reliance on manual or paper-based processes to manage a variety of patient records and other areas. The trust did not have routine access to patient data that was available in other NHS care settings and they did not use data as efficiently as they would like to. The digitalisation of patient records was part of the trust's plans, and this would help in collecting data in a more rounded way.

Work had continued around the rigour of documents control and best practice and there had not been any significant events, although some technical issues had needed to be addressed. The roll out of iPads for all front-line staff had continued in the time following our last inspection. These provided direct access to training and clinical guidance.

Since the previous inspection the trust had successfully completed a project with NHS Digital to provide access to the Summary Care Record application (SCRa) on the iPads. There were two key factors to this:

- The simple secure access to the NHS Spine using the biometric security capability of the iPad, which removed the need to use an NHS SmartCard or another username and password.
- A simple but effective dataset which introduced clinicians to the opportunities from accessing patient-data on scene to make better informed decisions.

The trust described examples of crews identifying having made a different decision or reaching a decision more quickly as a direct result of access to the SCR data. For example; a patient was conveyed to ED that they would otherwise have left at home. This decision was made having identified changes to a long-term condition which was not otherwise seen. Identifying next of kin details for a patient who was unconscious and unable to communicate.

There was an expectation in the future there would be further improvements in accessing summary care records (SCR). The trust had been given approval to access the system for these. SCR are an electronic record of important patient information, created from GP medical records. They can be seen and used by authorised staff in other areas of the health and care system involved in the patient's direct care. We were told LAS was the pan London host for local health and care records.

We were informed by the chief information officer there had been two breaches of information governance since the last inspection. One related to the incorrect application of access rights, which enabled a member of staff to access information. This was identified by another staff member and was reported correctly and acted upon in accordance with the serious incident process. A second incident arose from an external call system and the trust was able to use there processes effectively to capture, report and investigate the matter.

There was an internal medicines audit programme. Audits included security of medicines and medicines related stationary were undertaken by the audit team within the trust on behalf of the MMG.

Cyber security was recognised as being a continuing concern and was reflected on the corporate risk register and the board assurance framework. It was purposely broad and non-specific in its narrative. There was a dedicated cyber security team of four whole time equivalent staff. The lead person managed care alerts, compliance plans and the security of Networks and Information Systems (the NIS Directive, which relates to preparedness for cyber-attack).

We asked what the trust wished to showcase. We were told a great deal of effort had been put into rebuilding the IT infrastructure. This included replacing equipment and improvements to wifi access. There were new data centres and there was a focus on getting it right for staff. The trust had invested in getting the core infrastructure right to enable the next steps of the digital journey. This included new network links to provide secure and high-speed connections and a focus on making systems easy to use.

There were a range of systems in use for performance data collection. Information was collected, collated and reported into the various governance groups. This enabled oversight and agreement of actions, if required.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. Whilst the patient's forum reported less favourably on the relationship between the trust and themselves, in the main the trust collaborated with partner organisations to help improve services for patients.

LAS still worked closely with the five Sustainability and Transformation Partnership (STPs) in London and the 32 Clinical Commissioning Groups (CCG), with the lead CCG (Brent) engaging with all others for contractual and performance issues. We reviewed information related to several formal meetings held during the past year. These included for example; the Provider Oversight Meeting; CCG Clinical Quality Review Group meeting; North Central London's Sustainability and Transformation Partnership, and the Healthcare Partnership Programme Board. Information therein recorded indicated an open and collaborative relationship on the part of LAS and those membership groups.

NHS England told us that the LAS was low-risk and was generally well-governed and that there was much to commend. They advised us that trust was demonstrating significant vision and leadership in the development of integrated care services and was delivering results. The inspection took place at a time when the trust was not only changing its executive leadership; but was also developing and implementing a range of revised clinical and enabling strategies.

The trust was continuing to work with external partners, including GPs and social workers to implement frequent caller plans, as a means of managing such callers in a better way. Work was also taking place around the further development of patient pathways.

The trust acknowledged that relationships with Trades Unions were not as developed as it would wish. Improved communication strategies were being implemented that seemed fruitful. We heard of positive work related to the unions offering to encourage staff to take up the trust's vaccination programme.

As part of the digital programme of work, LAS was engaging with Londoners to understand the appetite, trade-offs and agreements that could be reached for use of data beyond direct care. The trust was working with stakeholder partners on behalf of the entire sector.

The lead for complaints told us they had recently set up a patient feedback group, the first meeting of which they had chaired. Stakeholders, including patient advocacy services were included in this. A decision had been made to have themed meetings, initially covering such areas as maternity, mental health and end of life. The meeting fed into the Quality Assurance Group and then the Trust Board.

The trust fully recognised there was a need to have a patient representative group which was truly reflective of the London community and they had mapped all the relevant stakeholders out with a view to developing this. There was, however, an active patient's forum, members of whom attended public board meetings and the annual general meeting. The trust took questions from representatives both prior to and during such meetings. The Patients' Forum for the LAS operated in a similar way to the way in which Local Healthwatch relate to their CCG's and Acute Hospital Trusts. An advantage of the forum for LAS is that it provided an informed London-wide source of patient and carer insights into the operation of the LAS.

The patient's forum took an active interest in the activities of LAS and sought to contribute to improvements in patients care. We saw an example of a request to involve the experiences of patients in improving care for patients who suffer Epileptic seizures. We followed this up with the

forum and were told they had been working with members who have epilepsy, carers and the Epilepsy Society to draw ideas together for service improvements for people who suffer from seizures. A proposal for service development was presented to the LAS in April. They reported to us that they found discussing the ideas quite difficult and there was little interest shown in these proposals. Further, we were informed by the forum that the trust seemed to lack insight into the difference between personal needs and service improvements.

We saw too that the forum worked closely with the LAS Academy at Fulham, which had responsibility for the education of Emergency Ambulance Crew who were training to become Paramedics.

We were provided with a report from the Patients Forum, which reflected their findings following a visit to the EOC earlier this year. The outcome of this was 28 recommendations for improvement for the patient experience.

The new LAS head of communication had invited forum members to join the new Advisory Panel to review LAS communications, including development of the LAS website.

The MMG worked with the pharmacy teams in adjacent trusts through networking groups including chief pharmacist, local and area prescribing committees.

There had been engagement with staff around the LAS strategy, recognising that they needed to be involved in its development and gained support from across the workforce. The strategy indicates that there were 1,600 separate contacts with staff through a range of methods including:

- CEO roadshows
- Staff strategy survey
- Strategy engagement day
- Managers' briefings
- LAS leadership event
- Strategy design workshop
- Team meetings
- Union meetings
- Directorate away days

The trust indicated they had engaged with 25 separate organisations about the strategic intent, starting with the sustainability and transformation partnership (STP) event on 1 November 2017.

The CEO produced videos by way of providing an executive update. We watched the video for 23 July, in which they described the appointment of the new chief operating officer (COO) and the advertisement of two new directorate support roles who would report to the COO. The CEO video of the 17 July included announcement of further filming of the LAS in the autumn.

The trust's chair had a blog, which we saw made reference to knife crime, decontamination and diversity, and being an inclusive organisation.

The clinical section of PULSE (the trusts main information intranet page for staff) included various sections covering topical matters under headings of clinical audit and research, infection prevention and control (IPC), Safeguarding, cardiac care, appropriate care pathways (ACP) and first responders. ACP are defined as any place of care, clinical team to which a patient can be

transferred or conveyed to receive care that is not an ED. The decision to access ACP may be made by LAS staff dealing with patient on scene or via telephone. Only emergency medical technician (EMT) level three or above could make an autonomous decision of conveyance or referral for.

We saw information on cardiac care, which included an update related to the normal electrocardiogram (ECG), adult basic and advanced life support, guidelines for admission of patients to heart attack, high risk ACS and emergency arrhythmias.

Information on new advance life support (ALS) red bags and the rollout of these was described to staff. These new bags had been designed and tested by staff. These were to replace the current personal issue paramedic bags and would ensure standardisation of equipment, with modular stocking of vehicle base bags.

The infection prevention and control (IPC) tab on Pulse described three ways of being able to get in contact with the IPC team and information about new hand hygiene wipes for occasions where ambulance staff do not have access to hand wash facilities. It was noted that Logistics were responsible for re-stocking vehicles with these items.

We were told by the safeguarding lead that it was a very different organisation to how it was a few years ago and even in the last year. They felt there was a high level of engagement with the CEO meeting with the top 50 managers regularly. This meeting included discussion of finances, estates for example. In addition to this there was a monthly '700' meeting with staff. This staff member reported feeling very involved in the decision making.

The trust lead for safeguarding participated in the Multi Agency Risk Assessment Conference (MARAC). These are meetings where information about high risk domestic abuse victims (those at risk of murder or serious harm) was shared between local agencies. Although the trust did not attend MARAC meetings they provided information to support discussions. In 2018/19 the LAS indicated they had supported over 2343 cases, which was an increase of 63% in the last three years.

As well as sharing information with a wide range of external organisations, the trust also participated through the provision of information or attendance at the Local Safeguarding Children Boards (LSCB). This board has a responsibility for making sure a review of each unexpected death of a child who resides in their area is undertaken by the Child Death Overview Panel (CDOP).

Learning, continuous improvement and innovation

The majority of staff were committed to continually learning and improving services. Leaders had a good understanding of quality improvement methods and had the skills to use them. Leaders encouraged innovation and participation in research.

LAS had a quality strategy, which included two main aims:

- To accelerate delivery of the highest quality, best value care, and best staff experience across LAS by 2020.
- To embed continuous improvement into daily operations and to ensure best support to the services across LAS.

The trust board had agreed in May 2018 to support the adoption of a standardised approach to quality improvement, based on Plan, Do, Study, Act (PDSA). The trust had selected a training package which was a toolkit approach to supporting PDSA and the use of a range of improvement

techniques. For example; understanding human factors, concept of safety systems, change management principles, and using lean approaches to flow and service re-design management and process mapping.

Since the last inspection the trust had continued to develop and deliver its training programme for quality improvement. The trust had also included its quality improvement methodology within the engaging and visible leadership course. We were told by the chief quality officer that quality governance assurance managers (QGAMs) were based in within each of the five sectors, and that there was a central quality improvement team with five members.

We asked what the 'hot spots' were for quality improvement and were told there had been challenges in the north west area around medicines management, which was still being monitored. As an improvement and learning exercise thematic reviews were used to drill down on certain issues. We reviewed evidence of such thematic reviews, including that pertaining to early defibrillation.

The trust executive team said they were aware of the areas which required continued focus and were not surprised by the feedback they received following the core service inspection findings. However, we found they had not had oversight of their internal policies and procedures, and until we made them aware of our concerns about the lack of update of these where changes arising from learning were needed, had not considered such actions. We were reasonably assured the trust took note of this and made immediate efforts to resolve this. We viewed a formal system which had been constructed in the time between our feedback and the well-led inspection. This was designed to enable improved oversight and governance of policies, procedures and guidance.

We reviewed the progress report on the strategy and noted the positive milestones met so far. This included for example; an improved incident reporting culture, with no harms reported at 2361 in 2017 to 2696 in 2018; low harm incidents increased to 537 in 2018 from 339 in 2017. The trust had seen a reduction in moderate harm from 145 to 89 and for severe harm from 67 in 2017 to 38 in 2018 respectively.

The trust's bi-annual update on the quality strategy indicated that the introduction of excellence reporting had made a significant impact. During 2017/18, 20 excellence reports had been produced, rising to more than 300 in 2019, including 64 for May 2019. Excellence reports were used to thank staff as well as to share learning and promote learning from excellence, with publications in the trust's INSIGHT magazine.

We noted the quality improvement strategy update indicated the remaining actions for the period up to March 2020. These included for example; The launch of QI and executive management team (ePMO) communications from November 2018; the development of QI hubs from October 2019, and the gathering of local ideas for triage through the Senior Leadership Group and Programme Management Board to enable oversight from 'floor to board.'

Since the last inspection other improvements had been made, including, the introduction of five septicaemia leads, the mobilisation of the integrated care system and the trust was now moving towards a digital electronic patient care record.

The trust participated in the sharing of NHS ambulance benchmarking medicines data and information. This provided benchmarking data and analysis of the trusts safe and effective use of medicines.

The trust rationalised and restricted the packaging of two infusions to reduce miss selection incidents. An education programme was developed and rolled out to minimise route and dose errors when treating anaphylaxis.

Since the introduction of the Integrated Urgent Care (IUC) services in north east London and south east London, a joint IUC Quality Governance and Risk Group had been set up to meet quarterly, with a purpose of reviewing compliance against quality indicators, identifying and addressing quality trends and to ensure consistent practice and shared learning across IUC sites.

We saw the IUC quality report for July 2019 and noted information was reported in line with the five domains of safe, effective, caring, responsive and well-led. It was noted that in terms of safety data was collected around serious incidents and adverse events, including those related to an inappropriate clinical assessment and management of a patient presenting with a stroke.

The number of incidents reported had decreased from 103 reported in June 2019 to 81 in July. We noted it had been reported that most incidents related to documentation of demographics, IT-related issues and authorised breaches of confidentiality, which were routinely reported in order to assure appropriate assessments of capacity.

The IUC quality report further described the work done to focus on skills development, with training provided to team managers and supervisors to encourage the use of reporting incidents through the electronic system. GP registrar training had also commenced in north east London IUC and there had been increased engagement across the STP, which was helping to identify the future workforce. Continuous professional development sessions were being introduced into south east London IUC, following the success of the clinical learning and review sessions held in the other IUC.

We noted the IUC quality report included data on call handling under effectiveness. Calls answered targets were set at above 86% and the data told us the target was exceeded across May, June and July 2019.

A detailed programme of work to improve the quality of services provided via the IUC was stated by the trust. We noted this identified key actions for each of the domains.

The roll-out of personal-issue iPads to all ambulance crews had resulted in staff having access to care plans for example, related to end of life, disease specific such as Addison's disease and chemotherapy. These were provided by GPs and allied health professionals via Coordinate My Care. Best practice protocols were also accessible to front line staff via, the Joint Royal Colleges Ambulance Liaison Committee guidelines, (JRCalc). We were told tailored pathway data based upon clinical need, location and time of day was available to help crews identify appropriate options other than conveyance to ED.

As the only pan-London provider the trust was aware their integration with partners across the health and social care system was more complex than most. The trust played a leading role in the creation of the London Digital Board which brought together the digital leaders from STPs/ICS', the GLA, local borough councils, NHS London regional teams and LAS to shape a clearly aligned strategy for integrated working. This was strengthened during development of the One London Local Health & Care Records (LHCR) programme which was now delivering integrated patient records across all providers in London. The trust was proud and encouraged to have the region ask LAS to lead this ground-breaking programme of work.

We asked the trust how it reviewed information and triangulated this as a means of looking at cause and effect in response times within the call handling system. We were provided with a monitoring harm document which made reference to the clinical safety escalation plan and clinical safety review. The latter part of which indicated it had been greed with NHSE / NHSI and Commissioners. We reviewed this to see if it contained any points of monitoring of the time to answer calls in the EOC and impact of any delays and could not see any such detail. We did not have reasonable assurance that the trust recognised the impact of staffs' inabilities to respond

immediately to the initial calls made through EOC, or the impact this may have had on the subsequent actions taken.

Incidents

Incidents were reported into an electronic data base. Information reported via this system was subject to review and considered in terms of the level of seriousness and if further investigation was required. Staff who had been trained to complete investigations using a root-cause analysis (RCA) approach were assigned to undertake the investigation through the Serious Incident Group (SIG), with subsequent reporting back to the SIG on completion.

We reviewed the Serious Incident Policy and procedure, which was next due for review in April 2020. Information included where it had been published to staff and when, such as via the Pulse web page, and LAS website. Links to other relevant documents had been included. The policy provided guidance on how and when in-depth investigations should be undertaken, duty of candour and when to notify CQC. The detail provided information to support a consistent approach and provided guidance on RCA approach, the reduction of repeat incidents and learning.

We noted the quality strategy indicated more than 75 staff had been trained in RCA processes, which had increased their capacity and capability to investigate incidents more thoroughly.

We attended two Serious Incident Group meetings prior to inspection. Papers were circulated in advance of these multidisciplinary meetings. Participants had the opportunity to hear a summary of each incident, to review associated information and to discuss and question the detail, with a view to agreeing the need to escalate for further investigation. Where the group agreed the latter, a member of staff who had been trained in root-cause analysis was assigned this responsibility.

We noted from information provided that LAS had a tiered system for learning from incidents, including individual learning from direct feedback and support, sector level monitoring and action on learning through thematic reviews within sectors and across the trust. Themes from SI's were discussed and monitored via the trust's Serious Incident Assurance and learning Group (SIALG).

Since the last inspection there had been thematic reviews related to delayed defibrillation incidents and incorrect doses of medicines administered in accordance with a patient group directive (PGD). Learning from thematic reviews and case studies of SI's were shared through specific learning events across the quality and medical directorates and the trust's INSIGHT magazine published information too.

It was noted that the trust provided a detailed report of SI's which had been closed by the CCG through the Quality Assurance Committee. We reviewed executive summary reports for a number of these, noting that one such review had resulted in the sharing of information with the National Ambulance Service Medical Directors (NASMeD) group for a thematic review.

We spoke about learning with members of the executive team. The medical director told us important messages were conveyed via pod casts, and 70% of these had been reviewed by staff, this included a message around automatic electronic defibrillators (AED) and the use of oromorph medicines. Team managers were briefed on learning too, and they were responsible for communicating with their staff. In addition, the trust used 'insight and clinical update', which was well-read. Where departments did not hold team meetings we were concerned that staff may not have always received information of importance, particularly as they did not always have the time or inclination to read other forms of communication containing learning.

The medical director told us team managers were doing some work to review the last few bulletins and assess with staff what learning they had taken from these. Information could also be assessed with regard to staff use of iPads for updating their learning.

Learning from deaths

The trust had been considering all unexpected deaths as part of its formal serious incident process, including reviewing preventing future deaths requests made by the Coroner. We were provided with evidence of these review through the SIG papers, within the associated meetings as well as the reporting process via The National Reporting and Learning System (NRLS). This is a central database of patient safety incident reports, and the Strategic Executive Information System (StEIS). This system facilitates the reporting of serious incidents and the monitoring of investigations between NHS providers and commissioners.

The trust had been proactive in developing a new system for learning from deaths in light of the July 2019 publication by the National Quality Board guidelines for NHS ambulance trusts to learn from deaths. The guidance provided a framework for ambulance trusts to identify, report, review and learn from deaths which occurred when patients were under the providers care. The process was similar to acute trusts.

We heard a presentation from the trust of what they were aiming to achieve and saw what the trust had achieved thus far. Important timelines had been identified, including the aim to publish the trust learning from deaths on the public website by December 2019, a commitment to publish the first set of quarterly data and by the summer of 2021 the provision of a summary of learning from deaths activity for the previous year. The trust had clearly stated which deaths would be reviewed within this process and how information would be shared with staff, other ambulance trusts and stakeholders.

We reviewed information which indicated the trust had been proactive in following up on recommendations which arose following the Gosport report. The trust had a working group to consider and take appropriate action on matters related to all the themes from the Gosport Independent Panel report.

Following on from our previous inspection findings around the end of life team which had been established, the trust had released in April 2019 the first suite of new end of life care guidance to support staff. The Advance Care Planning guidance provided a focus on lasting power of attorney, DNACPR orders and advance directives. The end of life care team held a live Facebook session on Thursday 6th June and took questions about the guidance.

Complaints process overview

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

Question	**In days**
What is your internal target for responding to complaints?	3
What is your target for completing a complaint	35
If you have a slightly longer target for complex complaints	90

please indicate what that is here	
Number of complaints resolved without formal process in the last 12 months?	4,316 (April 2018 to March 2019)

(Source: Trust Provider Information Request – Complaints Process Overview tab)

Summary of complaints

The trust received 1,104 complaints from April 2018 to March 2019, emergency and urgent care. received the most complaints with 517 (51.0%). Themes that received the most complaints were:

- Conduct and behaviour (29.8%),
- Delays (18.2%)
- Treatment (9.5%).
- Road handling (9.3%)

Core Service	**Number of complaints**	**Percentage of total**
Emergency and urgent care	517	51.0%
Emergency operations centre	380	37.5%
Other organisations	90	8.9%
Other	19	1.9%
Resilience	8	0.8%
Total	**1,014**	**100.0%**

(Source: Trust Provider Information Request – Complaints)

The trust also collected complaints data in respect to the Integrated Urgent Care Centres (IUC), which receive 111 calls from the public. We saw the IUC quality report for July 2019. We noted complaints, feedback or concerns ranged from the highest level of 97 in August 2018 to the lowest (14) in May 2019.

We reviewed the Complaints and Feedback Policy and Procedure, which was due for review March 2018. This contained links to other related documents and outlined responsibilities with delegation from the board to the complaint's champions, as executives or NED. Assistant directors of operations were accountable for ensuring full and timely response, and for ensuring learning outcomes were implemented. We noted complaints were RAG rated, low, medium and high risk and response times were described as: substantive to be closed within 25 days, if significant complexity, 35 working days and most serious 60 working days.

We spoke with two representatives from the complaints team who explained the improvements made since the previous inspection. There had been delays in getting information from other teams, such as clinical information from the medical director. This had now improved as a result of having a rota of clinicians available to the team. The clinicians (medical director, QGAMS and sector leads) worked with the complaints team one day per week to address relevant complaints where clinical oversight was required. Currently the clinical hub met once a week to support the complaints process, although it was expected the meetings would go to two-weekly in the near future.

The complaints team said the quality assurance around the review of 999 calls had improved and there was a dedicated quality officer who considered these once each week. The other improvement in complaints management had come about as a result of increasing the team size and improving flexibility within it. There was a rota system for managing quality, service improvement and redesign (QSIR), and at least two or three members of the team had a responsibility for chasing information as part of the complaints process. The more collaborative approach had led to an improvement in meeting closure targets, up from 53% to 94% for the 35 day target.

Recognising the complexities of some matters had resulted in the ones linked to a serious incident having a 90 day target, although commissioners had an update at 20 days. The trust had also recognised there were more complaints arising from individuals with mental health or learning disability needs. As a result, they had re-written the challenging behaviour policy collaboratively with the mental health team. Information on the public website had also been revised to support people in making a compliant. The team had worked and were continuing to do so with the EOC to try and align things which are more commonly complained about.

We were told the ombudsman complaints remained relatively constant, with two upheld, seven closed and four undecided at the time of our discussion. We asked about complaints arising from frequent callers and were told one frequent caller was also a regular complainant, which could be difficult, especially as they could be abusive.

The governance arrangements for complaints included performance reports to the Quality Oversight Group and quality reports to the CEO.

We reviewed the complaints process end to end and found the system to be very efficient, with a full audit trail, copies of acknowledgement letters and the final response, the latter of which contained an apology. Letters contained sufficient detail and information about the matter and identified where learning and improvement had arisen as a result of the investigation.

Research

The trust was implementing clinical research to inform the effectiveness of its interventions and to tailor further its services for cost effectiveness. This would feed into commissioning processes. We were told by the medical director that 300 staff were involved in clinical audit and research.

The medical director said it was important to make sure the info-graphics were used to update policies and procedures in light of any changes.

Innovation

The trust's clinical strategy set out its aims to be the primary integrator of access to the urgent and emergency care sector, through the provision of a fully integrated 111/IUC and 999 service across the whole of London. Currently the trust had 40% of London's 111/IUC provision and were already in a position to demonstrate the benefits of this; for example, a lower proportion of dispatch of ambulances or people taking themselves to hospital.

The trust had set out the key priorities and were working towards the implementation of an integrated clinical assessment and triage, known as iCAT. This would enable the joining up of 111, IUC and 999 in a more efficient and streamlined manner, thus giving patients a better experience.

Part of the trust's organisational strategy for 2018-2023 included the launch of its pioneering services. This related to five key areas where the trust felt they could reduce conveyance to hospital by making care closer to home. The five areas related to maternity care, mental health care, end of life, emergency responses and falls. We reviewed a presentation on the progress of these since our last inspection. Information provided to us made it clear that the trust was taking a proactive approach to leading on these areas. Further, they were working with other stakeholders, mental health trusts in a collaborative manner.

Compliments

From April 2018 to March 2019, the trust received a total of 1,570 compliments. The highest number of compliments were for emergency and urgent care, with 73.7% of the total compliments.

A breakdown by core service can be seen in the table below:

Core service	Number of compliments	Percentage of total
Emergency & urgent care	1,157	73.7%
Other	347	22.1%
Emergency operations centre	51	3.2%
Resilience	15	1.0%
Total	**1,570**	**100.0%**

(Source: Trust Provider Information Request – Compliments)

We reviewed the Pulse communication site, which was available to all staff via the intranet. There was a great deal of information to staff, some of which included personal thanks to the staff from the CEO for their commitment and hard work over the weekend period when the Notting Hill carnival was on and how they coped in very hot weather. It was noted that over the same weekend the 111 services received between 300-400 calls an hour at peak periods.

We observed a range of routine information bulletins were accessible via the PULSE page. Amongst this was a whole range of information, including; clinical information such as changes to CPI's, understanding anaphylaxis and alternative care pathways. We saw there had been an update on the Advanced life support bags, the content and provision of which had been reviewed. (Aug 27). There was a whole section on education and development, including preparing for PDR, interview skills for interviewees, recertification training for the special operations response team. Staff recognitions included letters of thanks and anniversaries. The LGBT network conference was highlighted, along with information on the BAME forum.

Ambulance services

Emergency operations centre

Facts and data about this service

The emergency operations centre in Waterloo handles 999 call functions for London together with the emergency operations centre in Bow. The dispatch area assigns fast response units, ambulances, and specialist according to patient's clinical need. The clinical hub area of the emergency operations centre at Waterloo has a clinical "Hear and Treat" service for suitable patients and gives clinical support to staff in the field.

Each centre operates on Command Point, a computer aided dispatch system. The trust uses the Medical Priority Dispatch System (MPDS) as a triage platform for 999 calls.

There are 500 staff members within the emergency operations centre made up of emergency medical dispatch staff and watch managers. There is a 50/50 split of staff between Waterloo and Bow.

Staff in the emergency operation centres includes:

- 19 operations managers and one general manager per site.
- 14 quality assurance staff members.
- 20 clinical team navigators with five managers at the clinical hub.
- 52 clinical advisors based across various sites.

(Source: Routine Provider Information Request (RPIR) – Centres tab)

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff but did not ensure everyone completed it.

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training.

A breakdown of compliance for mandatory courses from April 2018 to March 2019 for all staff in the emergency operations centre is below:

All staff groups

Training module name	April 2018 to March 2019				
	Trained staff	Eligible staff	Completion rate	Trust target	Met (Yes/No)
EPRR tactical commanders (3 years)	2	2	100.0%	85%	Yes
Infection prevention and control level 2 (1 year)	73	77	94.8%	85%	Yes
Resuscitation level 3 adults (1 year)	72	77	93.5%	85%	Yes
Equality, diversity, and human rights (3 years)	590	635	92.9%	85%	Yes
Health, safety, and welfare (3 years)	589	635	92.8%	85%	Yes
Medicines management (1 year)	71	77	92.2%	85%	Yes
Fire safety (2 years)	580	635	91.3%	85%	Yes
NHS conflict resolution (3 years)	69	77	89.6%	85%	Yes
EPRR JESIP commander e-learning (1 year)	17	19	89.5%	85%	Yes
Moving and handling level 2 (people handling) (1 year)	68	77	88.3%	85%	Yes
Resuscitation level 3 new-born (1 year)	67	77	87.0%	85%	Yes
Resuscitation level 3 paediatrics (1 year)	67	77	87.0%	85%	Yes
EPRR incident response (clinical) (1 year)	67	78	85.9%	85%	Yes
Display screen equipment (3 years)	252	295	85.4%	85%	Yes
Infection prevention and control level 1 (3 years)	530	635	83.5%	85%	No
Fraud awareness (no renewal)	527	635	83.0%	85%	No
Duty of candour (3 years)	518	635	81.6%	85%	No
Resuscitation level 1 (1 year)	518	635	81.6%	85%	No
Information governance (1 year)	498	635	78.4%	85%	No
Moving and handling level 1 (3 years)	510	651	78.3%	85%	No
EPRR incident response (EOC) (1 year)	41	156	26.3%	85%	No

In the emergency operations centre the 85% target was met for 14 of the 21 mandatory training modules for which staff were eligible. The service had an overall mandatory training completion rate of 84.0%, just below the 85% trust target.

The trust provided a breakdown of mandatory training completion split by staff group. The breakdown of training compliance by training module and by staff group for staff in the emergency operations centre from April 2018 to March 2019 is below:

Qualified ambulance service staff:

Training module name	April 2018 to March 2019				
	Trained staff	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Fire safety (2 years)	53	54	98.1%	85%	Yes

Health, safety, and welfare (3 years)	53	54	98.1%	85%	Yes
Infection prevention and control level 1 (3 years)	53	54	98.1%	85%	Yes
Resuscitation level 1 (1 year)	53	54	98.1%	85%	Yes
Infection prevention and control level 2 (1 year)	51	54	94.4%	85%	Yes
Resuscitation level 3 adults (1 year)	51	54	94.4%	85%	Yes
Information governance (1 year)	50	54	92.6%	85%	Yes
Medicines management (1 year)	50	54	92.6%	85%	Yes
NHS conflict resolution (3 years)	50	54	92.6%	85%	Yes
Moving and handling level 2 (people handling) (1 year)	49	54	90.7%	85%	Yes
EPRR JESIP commander e-learning (1 year)	17	19	89.5%	85%	Yes
Resuscitation level 3 new-born (1 year)	48	54	88.9%	85%	Yes
Resuscitation level 3 paediatrics (1 year)	48	54	88.9%	85%	Yes
EPRR incident response (clinical) (1 year)	47	54	87.0%	85%	Yes
Duty of candour (3 years)	45	54	83.3%	85%	No
Fraud awareness (no renewal)	45	54	83.3%	85%	No
Equality, diversity, and human rights (3 years)	33	54	61.1%	85%	No
Display screen equipment (3 years)	31	54	57.4%	85%	No
Moving and handling level 1 (3 years)	23	54	42.6%	85%	No

In the emergency operations centre the 85% target was met for 14 of the 19 mandatory training modules for which qualified ambulance service staff were eligible. Qualified ambulance service staff met the 85% trust target with an overall completion rate of 85.8%.

Qualified nursing staff

Training module name	April 2018 to March 2019				
	Trained staff	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Duty of candour (3 years)	4	4	100.0%	85%	Yes
Equality, diversity, and human rights (3 years)	4	4	100.0%	85%	Yes
Fraud awareness (no renewal)	4	4	100.0%	85%	Yes
Infection prevention and control level 1 (3 years)	4	4	100.0%	85%	Yes
Infection prevention and control level 2 (1 year)	4	4	100.0%	85%	Yes
Medicines management (1 year)	4	4	100.0%	85%	Yes
Moving and handling level 1 (3 years)	4	4	100.0%	85%	Yes
Resuscitation level 1 (1 year)	4	4	100.0%	85%	Yes

Resuscitation level 3 adults (1 year)	4	4	100.0%	85%	Yes
EPRR incident response (clinical) (1 year)	3	4	75.0%	85%	No
Fire safety (2 years)	3	4	75.0%	85%	No
Health, safety and welfare (3 years)	3	4	75.0%	85%	No
Information governance (1 year)	3	4	75.0%	85%	No
Moving and handling level 2 (people handling) (1 year)	3	4	75.0%	85%	No
NHS conflict resolution (3 years)	3	4	75.0%	85%	No
Resuscitation level 3 new-born (1 year)	3	4	75.0%	85%	No
Resuscitation level 3 paediatrics (1 year)	3	4	75.0%	85%	No
Display screen equipment (3 years)	2	4	50.0%	85%	No

In the emergency operations centre the 85% target was met for nine of the 18 mandatory training modules for which qualified nursing staff were eligible. Qualified nursing staff met the 85% trust target with an overall completion rate of 86.1%. However, care should be taken when interpreting completion rates due to small numbers of eligible staff.

Support to ambulance service staff:

Training module name	April 2018 to March 2019				
	Trained staff	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Infection prevention and control level 2 (1 year)	16	16	100.0%	85%	Yes
Equality, diversity, and human rights (3 years)	518	541	95.7%	85%	Yes
EPRR incident response (clinical) (1 year)	15	16	93.8%	85%	Yes
Medicines management (1 year)	15	16	93.8%	85%	Yes
Resuscitation level 3 adults (1 year)	15	16	93.8%	85%	Yes
Health, safety, and welfare (3 years)	499	541	92.2%	85%	Yes
Display screen equipment (3 years)	185	201	92.0%	85%	Yes
Fire safety (2 years)	493	541	91.1%	85%	Yes
Moving and handling level 2 (people handling) (1 year)	14	16	87.5%	85%	Yes
NHS conflict resolution (3 years)	14	16	87.5%	85%	Yes
Resuscitation level 3 new-born (1 year)	14	16	87.5%	85%	Yes
Resuscitation level 3 paediatrics (1 year)	14	16	87.5%	85%	Yes
Fraud awareness (no renewal)	442	541	81.7%	85%	No
Infection prevention and control level 1 (3 years)	438	541	81.0%	85%	No
Moving and handling level 1 (3 years)	449	557	80.6%	85%	No
Resuscitation level 1 (1 year)	436	541	80.6%	85%	No
Duty of candour (3 years)	434	541	80.2%	85%	No
Information governance (1 year)	416	541	76.9%	85%	No
EPRR incident response (EOC) (1 year)	18	131	13.7%	85%	No

In the emergency operations centre the 85% target was met for 12 of the 19 mandatory training modules for which support to ambulance service staff were eligible. Support to ambulance service staff had an overall mandatory training completion rate of 83.2%, which was just below the trust target of 85%.

NHS infrastructure support staff:

Training module name	April 2018 to March 2019				
	Trained staff	Eligible staff	Completion rate	Trust target	Met (Yes/No)
EPRR tactical commanders (3 years)	2	2	100.0%	85%	Yes
Fraud awareness (no renewal)	36	36	100.0%	85%	Yes
Duty of candour (3 years)	35	36	97.2%	85%	Yes
Equality, diversity, and human rights (3 years)	35	36	97.2%	85%	Yes
Infection prevention and control level 1 (3 years)	35	36	97.2%	85%	Yes
Display screen equipment (3 years)	34	36	94.4%	85%	Yes
Health, safety, and welfare (3 years)	34	36	94.4%	85%	Yes
Moving and handling level 1 (3 years)	34	36	94.4%	85%	Yes
EPRR incident response (EOC) (1 year)	23	25	92.0%	85%	Yes
Fire safety (2 years)	31	36	86.1%	85%	Yes
Information governance (1 year)	29	36	80.6%	85%	No
Resuscitation level 1 (1 year)	25	36	69.4%	85%	No
Infection prevention and control level 2 (1 year)	2	3	66.7%	85%	No
Medicines management (1 year)	2	3	66.7%	85%	No
Moving and handling level 2 (people handling) (1 year)	2	3	66.7%	85%	No
NHS conflict resolution (3 years)	2	3	66.7%	85%	No
Resuscitation level 3 adults (1 year)	2	3	66.7%	85%	No
Resuscitation level 3 new-born (1 year)	2	3	66.7%	85%	No
Resuscitation level 3 paediatrics (1 year)	2	3	66.7%	85%	No
EPRR incident response (clinical) (1 year)	2	4	50.0%	85%	No

In the emergency operations centre the 85% target was met for 10 of the 20 mandatory training modules for which NHS infrastructure support staff were eligible. NHS infrastructure support staff had an overall mandatory training completion rate of 89.6%, above the trust target of 85%. However, care should be taken when interpreting completion rates due to small numbers of eligible staff for some modules.

(Source: Trust Provider Information Request – Mandatory training)

Staff told us mandatory training was accessed in a number of ways including e-learning modules, completed with the use of a computer or through classroom based teaching sessions. Staff were given protected time to attend classroom based training.

Staff told us they were given a 20 minute ‘educational break’ each shift to ensure they caught up on any e-learning which they were required to do. However, four operational staff members told us they did not utilise this time for training because the IT systems were too slow. Instead, they would complete the training during a ‘training day’ or in their own time. Five members of staff we spoke with told us they did not find all of the mandatory training modules useful or relevant to their roles. The five members of staff we spoke with told us they had difficultly remembering information from the e-learning modules and suggested they could be more interactive to ensure the learning could be remembered. Staff told us they found health, safety and welfare, fire safety and resuscitation courses to be the most stimulating and preferred classroom based teaching to e-learning.

Managerial staff had good monitoring of mandatory training requirements for their team members. We viewed training spreadsheets which each manager kept. These showed who had outstanding mandatory training to be completed within their team. The training spreadsheet showed completed modules, future course dates, expiry of training and how often the course was required to be completed.

Senior management had good oversight of mandatory training which was monitored through the trusts quality oversight group (QOG) which met monthly. We reviewed minutes from QOG meetings which showed training performance had been discussed and actions clearly outlined.

Safeguarding

Not all staff understood how to protect patients from abuse. However, the service worked well with other agencies when abuse was highlighted.

Safeguarding training completion rates

The trust set a target of 85% for completion of safeguarding training. The tables below include prevent training as a safeguarding course. Prevent works to stop individuals from getting involved in or supporting terrorism or extremist activity.

A breakdown of compliance for safeguarding courses from April 2018 to March 2019 for all staff in the emergency operations centre is below:

All staff groups

Training module name	April 2018 to March 2019				
	Eligible staff	Trained staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults and children level 3 (3 years)	32	32	100.0%	85%	Yes
Safeguarding adults and children level 1 (3 years)	635	620	97.6%	85%	Yes
Prevent level 2 (3 years)	77	73	94.8%	85%	Yes
Safeguarding adults and children level 2 (clinical) (1 year)	77	73	94.8%	85%	Yes
Safeguarding adults and children level 2 (EOC/111) (1 year)	179	166	92.7%	85%	Yes

Prevent level 1 (3 years)	635	533	83.9%	85%	No

In the emergency operations centre the 85% target was met for five of the six safeguarding training modules for which staff were eligible.

The trust provided a breakdown of safeguarding training completion split by staff group. The breakdown of training compliance by training module and by staff group for staff in the emergency operations centre from April 2018 to March 2019 is below.

Qualified ambulance service staff:

Training module name	April 2018 to March 2019				
	Eligible staff	Trained staff	Completion rate	Trust target	Met (Yes/No)
Prevent level 1 (3 years)	54	53	98.1%	85%	Yes
Prevent level 2 (3 years)	54	53	98.1%	85%	Yes
Safeguarding adults and children level 1 (3 years)	54	53	98.1%	85%	Yes
Safeguarding adults and children level 2 (clinical) (1 year)	54	52	96.3%	85%	Yes

In the emergency operations centre the 85% target was met for all safeguarding training modules for which qualified ambulance service staff were eligible. Qualified ambulance service staff had an overall safeguarding training completion rate of 97.7%, better than the trust target of 85%.

Qualified nursing staff

Training module name	April 2018 to March 2019				
	Eligible staff	Trained staff	Completion rate	Trust target	Met (Yes/No)
Prevent level 1 (3 years)	4	4	100.0%	85%	Yes
Prevent level 2 (3 years)	4	3	75.0%	85%	No
Safeguarding adults and children level 1 (3 years)	4	3	75.0%	85%	No
Safeguarding adults and children level 2 (clinical) (1 year)	4	3	75.0%	85%	No

In the emergency operations centre the 85% target was met for one of the four safeguarding training modules for which qualified nursing staff were eligible. Qualified nursing staff had an overall safeguarding training completion rate of 81.3% lower than the 85% trust target. However, care should be taken when interpreting completion rates due to small numbers of eligible staff. Management staff told us that it was difficult to reach the trusts completion target due to the small number of eligible staff, for example, one person was on maternity leave which meant this member of staff was unable to complete their training and this impacted on the overall completion level.

Support to ambulance service staff:

Training module name	April 2018 to March 2019				
	Eligible staff	Trained staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults and children level 2 (clinical) (1 year)	16	16	100.0%	85%	Yes
Safeguarding adults and children level 3 (3 years)	31	31	100.0%	85%	Yes
Safeguarding adults and children level 1 (3 years)	541	528	97.6%	85%	Yes
Prevent level 2 (3 years)	16	15	93.8%	85%	Yes
Safeguarding adults and children level 2 (EOC/111) (1 year)	151	141	93.4%	85%	Yes
Prevent level 1 (3 years)	541	442	81.7%	85%	No

In the emergency operations centre the 85% target was met for five of the six safeguarding training modules for which support to ambulance service staff were eligible. Support to ambulance service staff had an overall safeguarding training completion rate of 90.5%, higher than the trust target of 85%.

NHS infrastructure support staff:

Training module name	April 2018 to March 2019				
	Eligible staff	Trained staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults and children level 1 (3 years)	36	36	100.0%	85%	Yes
Safeguarding adults and children level 3 (3 years)	1	1	100.0%	85%	Yes
Prevent level 1 (3 years)	36	34	94.4%	85%	Yes
Safeguarding adults and children level 2 (EOC/111) (1 year)	28	25	89.3%	85%	Yes
Prevent level 2 (3 years)	3	2	66.7%	85%	No
Safeguarding adults and children level 2 (clinical) (1 year)	3	2	66.7%	85%	No

In the emergency operations centre the 85% target was met for four of the six safeguarding training modules for which NHS infrastructure support staff were eligible. NHS infrastructure support staff had an overall safeguarding training completion rate of 93.5%, higher than the trust target of 85%. However, care should be taken when interpreting completion rates due to small numbers of eligible staff for some modules.

Information received prior to our inspection showed the service had improved its overall mandatory training compliance since the time of our previous inspection and was at 84% against a Trust target of 85%.

(Source: Trust Provider Information Request – Mandatory training)

EOC staff had access to on-line safeguarding training, which contained PREVENT. PREVENT training was introduced by the government in 2015 with an aim to help stop vulnerable people being exploited and drawn into terrorism. The safeguarding lead for the trust told us staff had time built in to their rota to complete training, and there had been lots of information about PREVENT through email, the routine information bulletin (RIB) and on the internal intranet. The safeguarding lead told us it was now their intention, that the safeguarding team was fully established, to deliver more face to face training. However, despite training figures showing compliance in some of the PREVENT training modules, the transfer of knowledge was not always achieved as five out of seven members of staff we spoke with could not recall what PREVENT was, whether they had completed the training or any information relating to it.

The trusts annual safeguarding report showed referrals from EOC, the 999 call-handling team and the clinical advisers, had almost doubled since last year's total of 652, to 1,250. The trust told us they felt this was due to improvements in training.

Although the trust was compliant in all staff groups for safeguarding mandatory training, during the inspection we had concerns regarding the knowledge of call handling staff in relation to safeguarding. Two members of staff told us they believed safeguarding only related to children and not adults. Another member of staff told us they were aware of what constituted a potential safeguarding alert but was unsure of the process to raise this. However, we spoke with a further four members of staff who told us they were confident in raising a safeguarding issue and had done so through the emergency bed service (EBS). There was better understanding of safeguarding from clinical members of staff than from non-clinical members we spoke with.

There were appropriate systems and processes in place for safeguarding vulnerable patients from abuse or harm. There was a safeguarding officer for the trust who was able to provide support and guidance for staff, although no staff we spoke with had accessed this person.

We found safeguarding information was accessible to staff, including links to elder abuse website and working together to safeguard children (Department of education, March 2015). The trust also gave staff a small safeguarding handbook which included detailed information on both adults and children at risk and included the referral process and assessing capacity. Staff safeguarding duties and responsibilities had been clearly outlined and staff had links to additional information related to training, key contacts and useful documentation via the Pulse site.

We reviewed the safeguarding adults in need of care and support policy, which had been published through Pulse and LAS website and announced on RIB. This included reference to department of health, safeguarding principles, outlined types of abuse, mental health conditions, and levels of training; one to five. Safeguarding supervision sessions were available to staff and they had access to safeguarding materials approved by Safeguarding Committee and lead Safeguarding Adult Board.

The safeguarding children and young people policy were also reviewed. We noted that staff within EOC and 111 could assess patients' needs and where relevant, made referrals to children's social care via EBS and or the Metropolitan Police about suspected abuse, neglect or harm. Child deaths were referred to an overview panel, having been referred to the EBS. Female genital mutilation (FGM) referrals were expected to be made via EBS, as per a flow chart provided within the policy.

Direct disclosure of FGM by a child was expected to be referred straight to police via 101 or 999 if an emergency. Information was provided on youth violence including sexual assault, child exploitation, including county lines, child sexual exploitation and radicalisation. The latter referred staff to other policies including, the prevent policy and procedure.

The chief quality officer held executive responsibility for safeguarding within the trust. They had overall responsibility to ensure referrals were made to the independent safeguarding authority. The trusts quality governance assurance managers (QGAM) and stake holder engagement managers (SEM) were responsible for representing the trust at local safeguarding boards.

One call handler gave an example of a safeguarding alert they had raised. They told us they were given positive feedback some weeks later by the local safeguarding authority who had thanked them for raising it and assured them it was an appropriate referral.

We reviewed the end to end process for reporting safeguarding concerns through EBS and saw there was a well-defined process, with clear reporting and audit trails, including the involvement of external stakeholders and local authorities.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

We observed staff in both EOC's using hand sanitiser gel before and after entry into the building. Staff had visibly clean uniform, desks appeared free of clutter and visibly clean.

We reviewed the trusts infection prevention and control (IPC) policy which was kept updated and accessible on the Pulse intranet site. There were also links to related documents, including: IPC handbook, management of sharps and inoculations policy, LAS uniform and workwear policy and waste management. There was not a separate policy in place specific to EOC but an overall trust wide IPC policy.

The policy defined roles of the trust board and responsibilities for monitoring the effectiveness of IPC, through its governance assurance framework and the annual IPC work plan.

We observed an emergency medical dispatcher (EMD) allocating a call to an ambulance crew where the patient was experiencing diarrhoea and vomiting symptoms. This information was not verbally relayed to the crew by the dispatcher, however, the crew may have seen written information which highlighted the diarrhoea and vomiting on their mobile data terminal (MDT).

Post inspection, the trust told us that the normal process for alerting crews to information from EOC is through electronic means, rather than verbally handing over information, which could extend overall dispatch times to patients.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment were not always safe and secure.

The trust had two EOCs based in Bow and Waterloo. During our inspection of the Bow site we had concerns regarding the environment. Staff complained of mice on the ground floor of the building and this was observed by the inspection team during a visit to the site. The trust had put rodent traps around the building to reduce infestation, but staff said this did not appear to be working. The trust provided us with information which showed they were acting to eliminate rodents at this site. It

was noted by the external agency employed to manage the infestation that staff had been feeding the mice which exacerbated the situation.

Staff also told us there was no heating or air conditioning on the second floor of the Bow EOC building and this would cause staff to feel unwell in the winter or during times of extreme heat. Staff understood cost to be a factor and we saw evidence via email that staff had complained about this to their immediate managers. Staff did not know of any plan to rectify these issues. After the inspection, the trust told us this was a known issue and there was an estates and security improvement plan underway to resolve this issue, this also included replacement of desks and lightening in both EOC's. The trust also held monthly 'mystery shopper' security audits which were conducted by the health and safety department. Average Trust-wide security compliance in February 2019 was 63%, which increased to 81% in June 2019.

Staff had raised security concerns at one of the EOC locations as the electronic gates which acted as the main entrance into the facility took a long time to close shut, allowing members of the public to walk into the compound. Staff told us of instances where homeless people had made their way into the grounds of the site causing a potential security risk. Post-inspection the trust told us they were aware of the slow closing electronic gates and all security gates were being assessed as part of the estate's security plan. The trust told us they would seek to correct the gates in due course.

Within both EOC's there were suitable equipment for staff to carry out their duties. Staff told us they had enough chairs with right level of back support, adjustable desks and secure lockers to keep personal items in. Within both EOC's there were large television screens which displayed information such as live performance, tracking of call activity, key person contact details and CCTV of areas throughout London.

Both EOC's were only accessible to staff through key swipe access entry. Inspectors had their ID checked before entering into the building.

Staff complained that the computer-aided dispatch (CAD) was sometimes slow to display information. This was a potential risk as it could impact on the speed of triage. Staff said the IT systems fluctuated and during busy periods could be slower than normal. Management staff we spoke with agreed that the CAD could be slow on occasions but did not feel this was a patient safety issue or a risk. At the time of inspection, we did not see this issue documented on the EOC risk register. However, post-inspection the trust told us they were aware of the issues with the CAD and we saw plans for this to be replaced in the immediate future.

Equipment we viewed had been safety tested and clearly labelled when the next test was due.

Staff raised concerns with the inspection team regarding the lack of prayer room at both EOC sites. Staff told us they were expected to pray in multi-use rooms and were often disturbed by other staff during prayer. However, post-inspection, the trust told us there was a dedicated prayer room on the Waterloo site and more work was needed to highlight this to staff.

Assessing and responding to patient risk

The service did not always identify and respond to risks well and in a timely manner.

Calls received into EOC were categorised with a priority level through the medical priority dispatch system (MPDS). MPDS was used by call handlers to make decisions and dispatch appropriate aid to medical emergencies. The system provided standard questions relating to a patient's condition and provided pre-arrival and care instructions to the patient. The CAD system listed calls in order and colour coded them to show their priority level. Calls could be re-prioritised if felt necessary by staff depending on clinical symptoms.

We observed calls which had been triaged by a call handler and sent to the dispatch area for assigning to an ambulance which were being held in the dispatch area due to lack of available resources. This was an issue highlighted in our previous inspection report. Staff contacted callers/patients at regular intervals to determine if a patient's symptoms had changed or worsened. If there were any changes then the patient would be re-triaged and if appropriate, a new priority level assigned. The team responsible for call backs was guided by a set of time frames of when a call required call back. As with our previous inspection, we found records which indicated they were not always able to meet these targets.

Mobile data terminals were used by ambulance crews. These devices were connected wirelessly to a central computer at the control centre and were used to pass details of calls to crews, log the time crews were mobile to attend patients, arrival times, and times crews left the scene. This enabled staff to locate crews in real time and provided information on their readiness to respond to emergencies.

Clinical staff were available within the EOC in an area known as the clinical hub (CHUB). The responsibilities of CHUB were to 'hear and treat' patients and provide clinical oversight of all calls awaiting an ambulance response. The CHUB was also available to offer clinical support to call handlers who may have medical queries whilst triaging a patient. During our inspection, we noticed on five separate occasions where call handling staff were unable to get hold of a clinical advisor working in CHUB, this was due to clinical staff either being on an existing call or busy carrying out documentation which meant they were unable to support call handlers. This meant the call handler continued on with the triage but was unable to gain clarity to a question. On occasions, this meant an ambulance being dispatched to a patient, who may otherwise have been assessed by CHUB as 'hear and treat'.

The trust told us that call handling staff should not be contacting the CHUB for clinical advice as part of the emergency call cycle. Calls should be completed and reviewed by the clinical hub based on the categorisation of the call post MPDS triage.

Post inspection, the trust told us they recognised that there is pressure on staff when demand is high and staffing is sub optimal. Establishment increased by 73 FTE since last year, the trust told us they continue to recruit, looking at ways to improve retention within existing staff groups, and reviewing rotas to better match staffing demand.

Clinical navigators working in the CHUB provided oversight of all calls within EOC and ensured responses were safe and appropriate to the needs of the patient, whilst considering appropriate utilisation of the trusts' vehicles and resources. However, two clinical navigators we spoke with said the queue was normally extensive meaning it was difficult to have complete clinical oversight. Staff told us the under-staffing in CHUB had been raised with senior managers and concerns regarding lack of clinical oversight had been raised a number of times. We spoke with three clinical advisors who echoed the clinical navigators concerns that there was an under-staffing within the CHUB. Staff told us the trust was fully established or near full establishment for clinical advisors, but they felt this still was not enough to keep patients safe and to ensure a good level of oversight within EOC. Post-inspection, the trust shared information with us which showed improvements had been made in filling vacant posts and they were actively working towards full establishment. The trust executive team did not appear to know of the concerns being expressed by CHUB staff regarding the staffing levels.

Staff told us they were increasingly concerned regarding their ability to cope with normal activity and were concerned with their ability to cope with any major unplanned event. Staff told us the weekend before our inspection, at one stage during the weekend, over fifty people were waiting for

their calls to be answered by call handling staff. The manager on duty raised this with the trusts incident and delivery manager as per the trusts escalation policy, however, they did not see any active response to help with the challenging demand. Post-inspection, the trust told us the weeks preceding our inspection, the service had seen a peak in call volume due to record high temperatures over the bank holiday weekend and the Notting Hill Carnival. Despite this they remained in the top five performing ambulance trusts throughout this peak.

Staff told us it was becoming increasingly common for patients to be waiting ten hours or more for an ambulance response. Staff told us the reason for this was under-staffing within the emergency and urgent care sector. However, post-inspection, we saw no evidence of data which showed this to be the case.

The trust told us that despite best efforts, the service's ability to answer 999 calls, was affected by unexpected peaks in demand. The trust told us there were additional safeguards in place during these peaks such as 'urgent disconnect' where a more concise exit message was given to the caller enabling the call handler to answer another call sooner. The trust also had a dedicated 'critical line' supported by British Telecom (BT) which enabled their operators to bypass call handlers and passes a call to EOC managers during busy periods when it was believed by the operator the caller may be critically unwell.

The challenging demand on resources meant dispatchers were not always able to allocate a crew with an appropriate skill mix in order to meet the care and treatment needs of the patient. One example we observed was dispatch staff allocating a first response unit (FRU) consisting of a solo paramedic, to an elderly female who had fallen and was unable to stand up unaided. The dispatch staff told the inspection team that normally a double crewed ambulance (DCA) would be sent to assist, as there would be two people to help the patient off of the floor; however, because of the lack of available DCA, an FRU was sent instead. Staff told us this was not ideal or appropriate but necessary when resources were low. This went against the trusts own health and safety policy aimed at reducing musculoskeletal injuries.

Post inspection, the trust told us that an FRU would be dispatched to ensure the welfare of the patient and undertake clinical assessment. However, further resources would be sent should they be required. The trust told us that an FRU being sent would not mean the solo clinician would be expected to lift a patient single handily.

The trust had a clinical safety escalation plan which outlined the process to follow in the eventuality the EOC sustained high pressure call volume, resources from the wider trust were released from normal duty and requested to support EOC staff. For example, when clinical staffing was low for the CHUB, staff which were trained operationally and in EOC were asked to come into EOC to cover shifts.

To ensure information was passed on at the completion of shifts, a formal handover took place between the off-going and on-coming dispatcher. The handover discussed types of calls sent to crews, the number of calls being held in the queue and any technical issues or crew delays.

Post inspection, the trust told us they were opening three clinical hub sites across London. These sites were available to work in for staff who were in date with their mandatory training and their quality assurance audits. Clinical advisors will have the opportunity to work from either of these sites which will reduce travelling into central London and to assist with a more flexible workforce.

The EOC had been successfully re-accredited as a Centre of Excellence (ACE) in the use of MPDS and was one of three accredited centres in England. The award is made by the International Academy of Emergency Dispatch (IAED).

Staffing

The service did not have always have enough staff working certain shifts. Staffing levels were not always planned to meet service demands.

Planned vs actual

The trust has reported their staffing numbers below for emergency operations centre as of March 2018 and March 2019.

Staff group	As at March 2018			As at March 2019		
	Planned staff - WTE	Actual staff WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Qualified ambulance service staff	30.0	29.1	96.9%	75.4	52.6	69.7%
Qualified nursing staff	0.0	2.7	N/A	2.9	3.9	133.3%
Support to ambulance service staff	574.8	519.3	90.3%	530.1	508.6	96.0%
NHS infrastructure support	34.8	33.2	95.2%	32.0	35.5	110.9%
Total	**639.7**	**584.2**	**91.3%**	**640.5**	**600.6**	**93.8%**

Fill rates for qualified ambulance service staff decreased from 96.6% in March 2018 to 69.7% in March 2019. While the service had an increase of 23.5 whole-time equivalent staff (WTE) actual staff, there was a greater increase of 45.7 WTE planned staff from March 2018 to March 2019, which contributed to the decrease in fill rates.

The trust did not plan for any WTE qualified nursing staff in March 2018, although, there were 2.7 actual WTE staff in post. The actual increase of 1.2 WTE compared to the increase of 3.9 WTE planned staff from March 2018 to March 2019, which contributed to the 133.3% fill rate.

Fill rates for support to ambulance service staff increased from 90.3% in March 2018 to 96.0% in March 2019. The actual decrease of 10.7 WTE staff compared to the decrease of 44.7 WTE planned staff from March 2018 to March 2019, which contributed to the increase in fill rates.

Fill rates for NHS infrastructure support staff increased from 95.2% in March 2018 to 110.9% in March 2019. The actual decrease of 2.3 WTE staff compared to the decrease of 2.8 WTE planned staff from March 2018 to March 2019, which contributed to the increase in fill rates.

The EOC operated a watch based roster system comprising of five watches (A to E) which ran concurrently. The vast majority of EOC staff followed a fixed roster that incorporated a relief week of 24 hours where they could be rostered to work any shift required by the trust. In order to provide as much notice as possible whilst allowing time to identify those shifts which may require additional resources, relief shifts were planned a number of weeks in advance.

(Source: Trust Routine Provider Information Request– Total staffing)

Vacancy rates

From April 2018 to March 2019 the trust reported an annual vacancy rate of 7.6% for the emergency operations centre. The trust target vacancy rate was less than 5%.

A breakdown of vacancy rates by staff group is shown below:

- Qualified ambulance service staff: 37.0%
- Qualified nursing staff: -8.5%
- Support to ambulance service staff: 4.1%
- NHS infrastructure support staff: -1.6%

Qualified ambulance service staff had the highest vacancy rate of 37.0%. This was due in part to an increase of 44.7 in planned WTE staff between March 2018 and March 2019 which added to the high vacancy rate.

Qualified nursing staff and NHS infrastructure support staff had negative vacancy rates. This shows that there were more actual WTE staff in post than planned.

(Source: Trust Routine Provider Information Request– Vacancy)

Turnover rates

From April 2018 to March 2019 the trust reported an annual turnover rate of 18.2% for emergency operations centres. The trust target turnover rate was less than 10%.

A breakdown of turnover rates by staff group is shown below:

- Qualified ambulance service staff: 8.5%
- Qualified nursing staff: 0.0%
- Support to ambulance service staff: 20.2%
- NHS infrastructure support staff: 3.2%

(Source: Trust Routine Provider Information Request– Turnover)

Sickness rates

From April 2018 to March 2019 the trust reported an annual sickness rate of 6.3% for emergency operations centres. The trust target sickness rate was less than 5%.

A breakdown of sickness rates by staff group is shown below:

- Qualified ambulance service staff: 3.7%
- Qualified nursing staff: 1.1%
- Support to ambulance service staff: 6.7%
- NHS infrastructure support staff: 3.4%

(Source: Trust Routine Provider Information Request– Sickness)

Nursing and medical bank and agency/locum staff usage

The trust did not report any agency or bank staff usage in the emergency operations centre.

(Source: Trust Provider Information Request – Bank agency locum tab)

Temporary staff usage

The trust did not report any temporary staff usage in the emergency operations centre.

(Source: Trust Provider Information Request – Temp staff tab)

All members of staff we spoke with told us their main concern was staffing levels. During our inspection, management staff told us they were 33 call handling staff down from planned levels. Staff were able to provide us with rotas and live information which recorded planned levels of staffing against actual staffing levels. During a review of the rotas and scheduling lists we noticed an increasing deficit of staffing levels. In a three week period, prior to our inspection, we noticed only three occasions where staffing levels had met or exceeded planned levels. Staff told us they would often be 20 to 35 call handling members of staff short of the planned requirements per shift.

After the inspection, the trust gave us an explanation to the perceived low staffing levels. The trust told us the rota's in place during inspection were reflective of EOC prior to the staffing restructure and did not show an accurate representation of the required staffing levels. The trust felt they had enough staff in post to ensure a safe service but told us they were working to place staff onto the right shift patterns based upon predicted call volume and considering the new staffing structure. The trust told us they had plans to carry out an independent review of staffing levels within EOC. We were also told there was further work to do to ensure staff in EOC were accurately informed of the planned staffing levels to ensure there was no confusion on how many staff were required per shift.

Management staff told us staff sickness had been increasing and they felt this was due to the under-staffing of call handlers which meant existing call handers were far busier than the management staff considered to be safe. Five call handling staff we spoke with told us they were actively looking for other opportunities outside of the organisation because the lack of available staff meant their roles had become increasingly difficult and challenging.

A review of the rotas showed that planned levels of staffing was based upon historical call volumes and predictions. Staff told us they did not feel call handling staffing levels were safe for the amount of calls which needed to be answered. Staff felt this had direct impact on call performance and quality.

However, staff felt they had adequate breaks and time off between shifts. Whilst shifts were very busy for call handling staff, they felt immediate management were supportive of them taking a break if they required it.

Quality assurance staff, responsible for auditing calls and scoring performance of EOC staff, told us they felt call quality was negatively affected when staffing levels were low. Mistakes in triage

increased within the call handling staff group when staffing levels were low. For example, quality assurance staff told us they often looked at the dates and times of when most calls had failed the required level of quality assurance and noticed these were often at times of peak demand, when staff were under most pressure. Quality assurance staff told us there was not one mistake which was most common for failing the required assurance level, but more a number of mistakes which lead to an overall decrease in quality. However, staff were unable to provide us with specific incidents where this had happened.

Management staff told us there was ongoing recruitment into the call handling role, however, high staff turnover meant call handlers were often not staying for long after completing their initial training. A review of four exit interviews, conducted on call handling staff who had since left the organisation, showed lack of staffing was a contributing factor on their decision to leave. Post-inspection the trust told us there was a plan to increase call handling staffing levels in EOC. This plan included the implementation of new training courses and a rolling-recruitment campaign aimed at inviting people to consider joining the service as a call handler.

Dispatch staff were often ‘doubled up’ on their sector, meaning they would have to help cover two regions instead of one. This meant staff were responsible for allocating ambulances within two large geographically areas, instead of one region, as per normal. Staff we spoke with said this happened due to lack of staffing. Staff found being ‘doubled up’ a challenge because they were now responsible for twice the area than normal with double the resources to oversee. Management staff told us they did not keep a record of how often ‘doubling up’ occurred but did tell us that they felt it was increasing.

The trust had a process to mitigate the risk of reduced staffing cover which included a fast-text messaging service which sent a message to off-duty staff to seek cover for vacant shifts. The trusts scheduling department was responsible for sending this out. Scheduling staff told us the text messaging service was increasingly being used to try and cover shifts’ the trust was unable to supply us with information which showed how often the fast-text messaging service had been used.

Call handling staff we spoke with did not understand the Resourcing Escalatory Action Plan (REAP) or how this was used to identify significant or sustained levels of activity. However, management staff we spoke with did have a good understanding of this. During inspection, we saw an up to date REAP plan, with contact numbers available on how to contact local trust and operational commanders.

Post inspection, the trust told us they recognised the operational vacancies within EOC and told us they had a recruitment plan in place to ensure that full staff establishment is achieved. This is reflected in the recruitment plan submitted to us by the trust.

Records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

The trust recorded all calls within EOC for safety and performance monitoring. The EOC handled 999 calls only. We observed call handlers and clinicians updating patient records during and after

calls, ensuring information was as accurate and up to date as possible. All non-conveyance of patients was recorded in their record with a reason for the non-conveyance.

Special patient notes were flagged to call handling staff with information relating to the patient. Information such as 'do not attempt cardiopulmonary resuscitation' (DNACPR) orders, anticipatory care plans and fragility notes were available to staff to view.

All end of life care patients with a DNACPR were flagged through an electronic app. Staff in EOC tag the alert to the call and an urgent crew update is sent to the crew via their MDT. Ambulance crews would then be able to access full patient records directly on their electronic device.

Prior to inspection, the CQC received a regulation 28 report issued by a coroner regarding information which had not been relayed to a receiving ED. Regulation 28 reports are issued by a coroner when the coroner remains concerned that, despite evidence given by witnesses including the registered provider, similar incidents could occur. The incident involved a crew relaying vital information to a staff member within EOC who then relayed the information to the ED where the crew were taking the patient to. However, vital information was not corroborated between EOC and the frontline ambulance crew, meaning the ED were not fully prepared to receive the patient. The trust submitted a full response to the coroner regarding this incident which included actions taken to ensure a reoccurrence of this situation was kept to a minimum. The trust told us they had re-issued guidance to clarify the relevant details expected during pre-alert calls and stipulated a mnemonic (CASMEET) should be used when taking information from crews.

Notes were securely stored on the electronic system. However, we noticed staff did not always lock their computer when leaving the room. We noticed this on four separate occasions.

Confidential waste was disposed of in designated confidential waste disposal bins situated throughout the EOC.

Medicines

Staff gave advice on medicines in line with national guidance.

Call handlers gave medicines advice supplied to them through the MPDS system. Call handlers understood their limitations in offering advice relating to medicines and the importance of giving advice accurately and clearly.

Call handlers could only advise patients to take paracetamol, ibuprofen or medicines prescribed to the patient following the instructions on the prescription. We observed call handlers and clinicians giving clear advice regarding medicine administration.

Clinicians had access to a national poisons database. We observed clinicians using this database to check toxicity of drugs and to provide advice and guidance to the caller or patient.

Incidents

The service did not always manage patient safety incidents well. Managers investigated incidents and shared lessons learned. However, staff did not always have the opportunity to read information. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers did not always ensure that actions from patient safety alerts were implemented and monitored.

There was limited evidence of staff acquiring measurable learning from incidents both within the EOC service and across the trust.

There was a mixed response from staff we spoke with regarding how to report incidents through the trusts electronic reporting system. Two members of staff told us they would report any

potential risks and four staff members told us they were unsure of what the incident reporting system could be used for but would probably inform the supervisor on shift if they had any concerns. One call handling member of staff told us they had completed an incident form regarding the affect lack of staffing was having on call answering performance, to be told by their manager that this was unnecessary and not to do it again.

Staff were not always aware of learning from incidents. Staff told us they did not have any formal meeting held within their teams and all learning would come from checking their emails and reading bulletins. Staff told us they did not always get time to read their emails or bulletins and would normally hear of incidents through word of mouth. Staff felt there was little or no shared learning across both EOC sites. All EOC staff received a 20 minute education break which could be used for updates via emails and bulletins, on an average of four shifts per week, this equated to 1 hour 20 minutes per staff member.

However, five members of staff told us the 20 minute 'educational break' did not provide enough time to complete all required activities, staff sighted a slow IT system as the main barrier to this.

The trust provided us with information which highlighted work which had been undertaken to ensure staff learned from incidents. This information included evidence of staff involvement in focus groups, staff surveys and their input in identifying solutions for a thematic review. The trust also outlined other measures to ensure wider learning had taken place such as; a weekly email which was sent to all EOC staff which includes bulletins and updated information, a two-page monthly newsletter which was an amalgamation of the month's weekly emails and Insight magazine which included an EOC-related case study, which was distributed to all staff.

Television screens were used in both EOC's and these contained information on changes to process as a result of incidents. We saw an 'ineffective breathing' bulletin being displayed on the screen. However, three staff members told us because they were busy on their shifts, they would not normally take notice of information displayed here.

Clinical advisors working within the CHUB had a good understanding of the incident reporting process, learning from incidents and gaining feedback from incidents they may have been involved with. Clinical staff were able to give clear examples where their practice had changed as a result of an incident. One example was ensuring callers were in the same room with the patient so that clinical assessment could be as accurate as possible.

Duty of candour is a regulatory duty that relates to openness and transparency. It requires the providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Clinical advisors within EOC had a good understanding of duty of candour and gave examples where this had been applied. However, five call handling staff we spoke with were unable to give us a clear definition of duty of candour and situations it may be applied.

Staff told us that after serious incidents and major events, a debrief was held to ensure any support was identified and immediate learning could take place. Staff found these debriefs to be helpful and felt management staff supported them following traumatic or stressful calls. Staff could access further support from occupational health or the Trauma Risk Management (TriM) peer support system if required.

The trust identified common themes from incidents including, response delays, inappropriate triage and wrong response priority. The trust liaised with the clinical commissioning group (CCG) with regards to capacity and ability to cope with demand.

The trust completed a root cause analysis and implemented action plans as a result of identified incidents. During our engagement with the trust, we saw a number of action plans and implementation of control measures to ensure repeats of incidents were avoided.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From May 2018 to May 2019 the trust did not report any incidents classified as never events for the emergency operations centre.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 47 serious incidents (SIs) in the emergency operations centres, which met the reporting criteria set by NHS England from May 2018 to May 2019.

A breakdown of the incident types reported is shown below:

Incident type	Number of incidents	Percentage of total
Treatment delay meeting SI criteria	43	91.5%
Sub-optimal care of the deteriorating patient meeting SI criteria	2	4.3%
Adverse media coverage or public concern about the organisation or the wider NHS	1	2.1%
Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant)	1	2.1%
Total	**47**	**100.0%**

(Source: Strategic Executive Information System (STEIS)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care. However, staff did not always have access to updated policies.

MPDS was used to assess and prioritise emergency calls within the EOC. The system was updated regularly and included changes based upon national guidance and procedures in management of emergency medical conditions. During our inspection, management staff told us the MPDS system was due to be upgraded and staff would need training before the

implementation. However, management staff said they did not have the capacity or time to train call handling staff on the changes. This would need to be factored in the planning and arrangements when the system gets changed. and it would be likely staff would continue to use an updated system without the required training beforehand.

Staff had access to policies and procedures available through the internal intranet. Staff told us there was a frustration that alert bulletins, containing changes to policy, were not updated within the main policy itself. On review of the policies available to staff we noticed a significant number of polices had not been reviewed and did not contain information relating to the changes staff had received through the bulletin.

Out of date policies included: control services – call taking procedures (review date September 2018), policy and procedure on ambient listening (review date June 2017), control services – call taking procedures (review date September 2018), procedure for vehicle equipment use and inventory checks (review date October 2015), stroke care policy (review date October 2018) and resuscitation policy (review date January 2018). We noted a number of other policies which had not been reviewed or updated, and we brought this to the attention of the trust.

After the inspection, the trust sent us a written response outlining actions which had been taken to ensure policies were updated. The director of corporate governance now ensured policies were up-to-date and easily accessible to staff. A review of the trusts policy register had also been undertaken in line with the trusts policy for the development and implementation of procedural documents. Responsible managers and directors had been identified for each document on the register, together with the approval route for that document.

Staff were able to access National Institute of Clinical Excellence (NICE) guidance through the trust's intranet. We observed staff from the CHUB utilising this when they are assisting a road crew with the treatment of a patient. For example, we saw a clinical advisor assisting a crew with the right treatment path for a patient who had received a head injury. NICE guidance was used in determining the correct treatment plan.

Call handlers completed reflective practice and were able to listen back to their own calls if recommended to do so by the quality assurance team, staff told us they found this to be a beneficial way of reflecting back on their own practice.

EOC staff had access to airwave radios, mapping systems and caller identification to speed up the process of locating a patient.

Staff working on the advanced paramedic dispatch desk had standard operating procedures (SOP's) available to them to assist in their duties. The advanced paramedic team were responsible for keeping SOP's relating to their practice updated and we saw evidence they were up to date with a review date clearly outlined.

We observed staff telling patients to call back if they needed further help or assistance and gave clear worsening advice before ending a call.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief advice in a timely way.

MPDS included pain scoring and we observed questions being asked around pain and these were recorded accurately within the patients record.

Clinical staff were observed to be asking their own supplementary questions around pain and giving advice and guidance for pain in line with national recommendations.

Response times

The service monitored but did not always perform well when compared to the England average

Ambulance systems (AmbSYS) indicators

The ambulance systems (AmbSYS) indicators were introduced under the NHS England Ambulance Response programme (ARP) in 2017. At this time, all measures of ambulance systems performance were changed to reflect new ways of working.

The following measures were introduced for this trust in November 2017 to reflect the new way of working under the ARP.

Time to answer calls

The time to answer each call is the time in seconds between call connect (the time at which the call is connected to the emergency operations centre telephony switch) and call answer (the time at which a call taker picks up the call and begins communicating with the caller).

This dataset includes 999 calls but does not include calls from NHS 111, unless the call from NHS 111 was transferred directly through to the 999-emergency line. It also does not include calls which were abandoned.

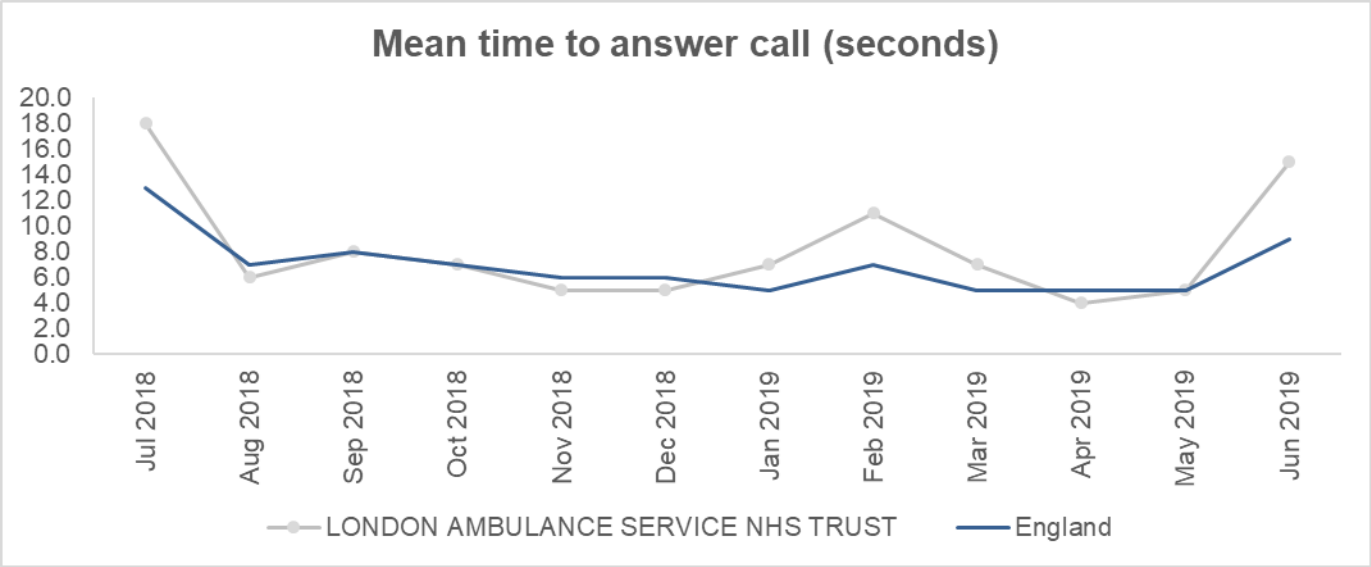
Median time to answer calls

The median time to answer calls shows the time in seconds within which half (50%) of all 999 calls were answered at the emergency operations centre. Quicker times are better with comparisons made against the England average for all ambulance providers.

From July 2018 to June 2019 the trust's median time to answer calls was consistently better than the England average. The trust had a median time to answer calls of less than one second.

Mean time to answer calls

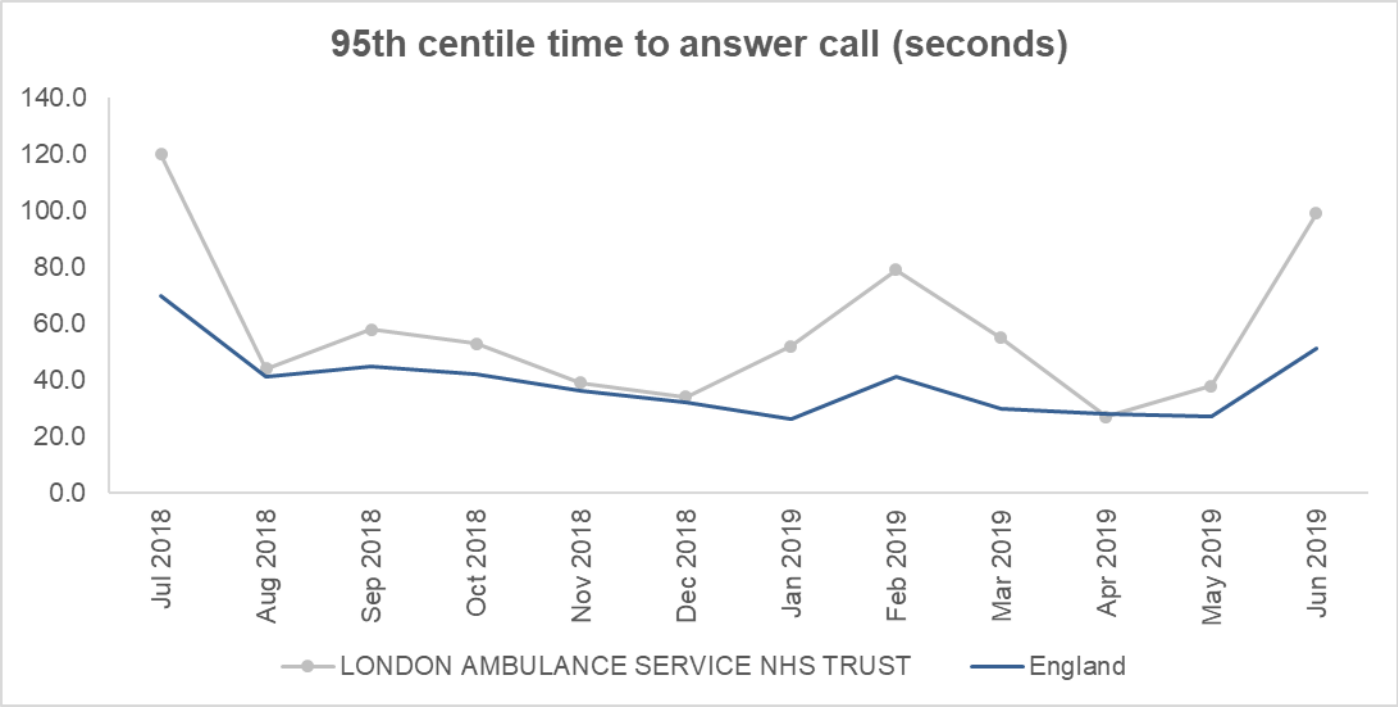
This measure shows the mean (average) time in seconds to answer 999 calls at the emergency operations centre. It is calculated as the total time to answer calls divided by the total number of calls answered in the same period. Quicker times are better with comparisons made against the England average for all ambulance providers.



From July 2018 to June 2019 the trust's mean time to answer calls was better for seven and worse for five months compared to the England average. The mean time to answer calls at the trust followed the same trend as the England average over the period. Trust performance however, was noticeably worse than the England averages in July 2018, February 2019, and June 2019.

95th centile time to answer calls

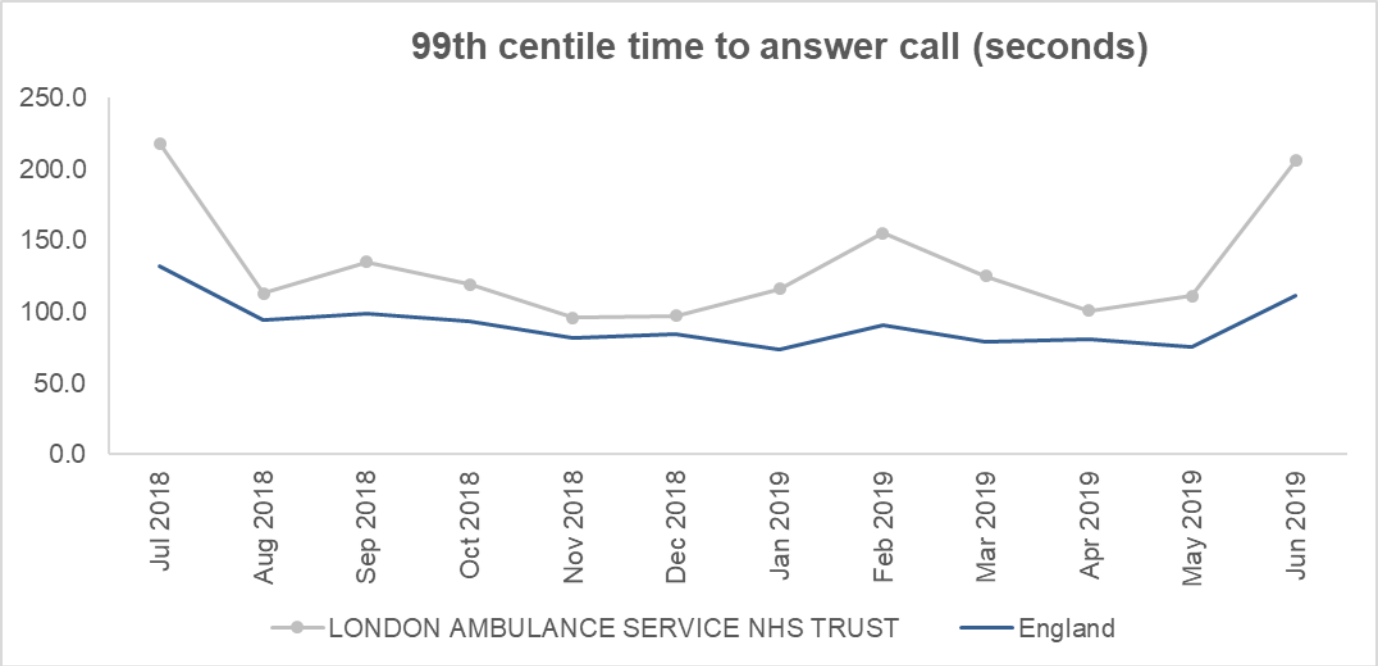
This measure shows the time within which 95% of all 999 calls were answered at the emergency operations centre. Quicker times were better with comparisons made against the England average for all ambulance providers.



From July 2018 to June 2019 the trust's 95th centile time to answer calls was worse than the England average for 11 of the 12 months. The trust took an average of 58.2 seconds to answer 95% of calls compared to the England average of 39.1 seconds

99th centile time to answer calls

This measure shows the time within which 99% of all 999 calls were answered at the emergency operations centre. Quicker times were better with comparisons made against the England average for all ambulance providers.



From July 2018 to June 2019 the trust's 99th centile time to answer calls was consistently worse than the England average. The trust took an average of 132.7 seconds to answer 99% of calls compared to the England average of 91.3 seconds

(Source: NHS England – Ambulance Quality Indicators – System Indicators)

Patient outcomes

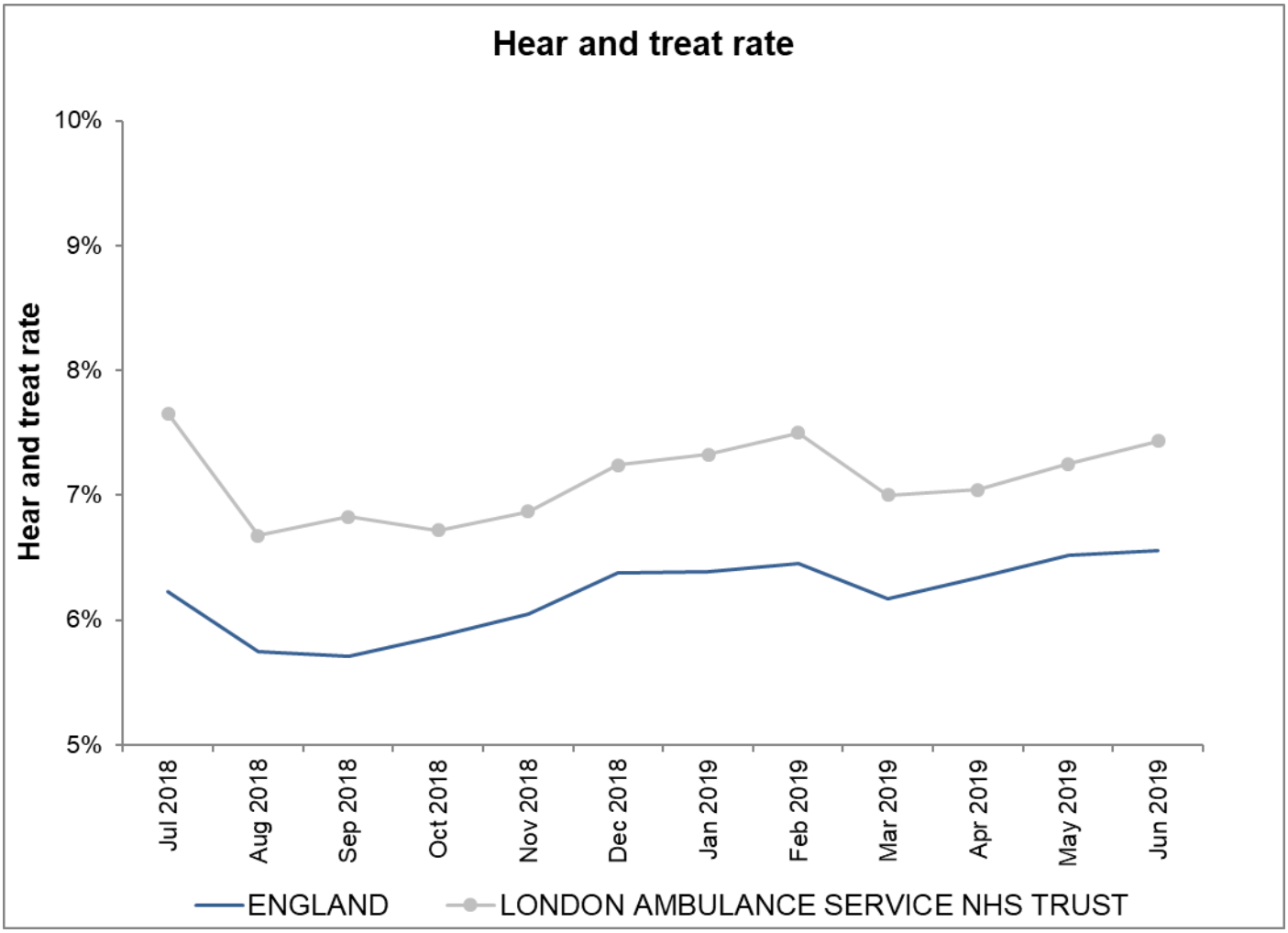
The service monitored the effectiveness of care and treatment.

Calls closed with telephone advice / hear and treat

This measure relates to all calls to the emergency operations centre that are resolved through telephone advice or by referring to another service and where an ambulance is not dispatched, i.e. there was no face-to-face response.

Please note that this measure has been included for context and is not a measure of performance.

Trust percentages against the metric for the period from July 2018 to June 2019 is below.



From July 2018 to June 2019 the proportion of incidents resolved without a face-to-face response at the trust was consistently higher than the England average over the 12-month period. The trust's performance ranged from 6.7% (August and October 2018) to 7.7% (July 2018) compared to the range in the England average of 6.2% to 6.6%.

In the most recent month, June 2019, 7.4% of incidents at the trust were resolved without a face-to-face response which was higher than the England average of 6.6%. Overall an average of 7.1% of calls at the trust were resolved without face to face response compared to the England average of 6.2%.

Hear and treat rates had improved by 3% when compared to last year.

(Source: NHS England – Ambulance Quality Indicators – Systems indicators)

The trust had a clinical audit and research unit and research and development co-ordinator which ensured clinical audit was progressing as planned and to quality assure collected data. The trust had a number of clinical audit projects including: the assessment and management of patients presenting with acute heart failure, assessment and advice given to non-conveyed paediatric patients with pyrexia, assessment and management of transient loss of consciousness and examining end of life care. The trust also monitored patients involved in the return of spontaneous circulation (ROSC). Detailed data for audits was reported under the urgent and emergency care core service report.

The trust was working with stakeholders and other healthcare agencies to support 'frequent callers. The trust was working to identify management plans for frequent callers to ensure their

needs were being met and to reduce burden on resources. The trust also increased the number of staff within the dedicated frequent caller team.

Competent staff

The service made sure staff were competent for their roles. However, managers did not always appraise staff's work performance and did not always hold supervision meetings with them to provide support and development.

Appraisal rates

As from March 2019, 57.4% of staff within the emergency operations centre at the trust received an appraisal compared to a trust target of 85%.

The breakdown by staff group is shown below:

Staff group	Mar-19				
	Eligible staff	Staff who received an appraisal	Completion rate	Trust target	Met (Yes/No)
Qualified ambulance service staff	53	32	60.4%	85%	No
Qualified nursing staff	4	2	50.0%	85%	No
Support to ambulance service staff	451	268	59.4%	85%	No
NHS infrastructure support	36	10	27.8%	85%	No

The service did not meet the 85% trust target for any of the staff groups. However, care should be taken when interpreting completion rates for qualified nursing staff due to a small number of staff eligible to receive an appraisal.

(Source: Trust Provider Information Request – Appraisals)

During our inspection, we saw evidence of an increase in appraisal rates for EOC staff. Evidence showed appraisal rates had increased to 78.62% which was still under the trust target but improved from initial figures supplied to us. The trust told us that most staff were new in their roles, this meant it was too early to start appraising these staff members.

Staff told us they did not find the appraisal process was worthwhile, opportunities for discussion were often not provided and training and development needs, whilst identified during the appraisal process, had no follow up and were not acted upon. Five staff members told us they felt it was a 'tick box' exercise and not used for genuine personal and professional development.

New call handlers and dispatch staff had a comprehensive induction period. Call handlers completed a five-week training programme to ensure they were able to use decision making software safely and accurately. Depending on the number of hours a call handler was contracted per week, a percentage of their initial hours would be receiving support and guidance from another member of staff until they were 'signed off' as competent on their own.

Management staff we spoke with had concerns that relatively new members of staff were being asked to coach and support other new members of staff. One example given to us was a call handler who had been in post for seven months was responsible for mentoring a new call handler

straight from training. Staff told us this was due to the lack of experienced staff working within EOC.

'Sign off' was deferred if a new member of staff was unable to meet a required standard and they were given additional support by the QA team as well as their immediate line manager. Staff told us they were often not referred back to the training team but managed operationally.

Dispatch staff were required to attend a three day course prior to commencement of their role. Training covered a wide range of potential callers, resource management and further training on new software systems.

The CHUB desk was overseen by the clinical navigator and was staffed by paramedics who also worked operationally. Staff were required to work 10% of their shifts providing clinical advice via telephone to ensure their competence was maintained.

Incident response officers had completed an operational commander course and attended the Joint Emergency Services Interoperability Programme (JESIP) training prior to commencement of their role. JESIP was established in 2012 to address the recommendations and findings from a number of major incident reports and was supported in 2013 with the release of the 'Joint Doctrine Interoperability Framework. They were required to undertake training every three years.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

The trust worked closely with the Metropolitan Police Service (MPS) to co-ordinate responses to emergencies which required both services to attend. The trust had a METDG desk which was overseen by one member of staff who sole purpose was to liaise with police colleagues. Both organisations had computer systems which allowed for information to be passed back and forth. However, staff told us these systems could be slow at times and often they would instead phone the police for quickness.

Call handlers were provided with advice and guidance on how to redirect callers to the 111 service, the NHS non-emergency number. Staff told us they would often receive calls from patients who were told to hang up and dial 999 for an ambulance from 111, instead of 111 passing the call through the computer system to 999. This meant calls received this way would require a new triage which could cause delay to patient care.

Call handlers did not participate in any form of engagement with the 111 service. There was no evidence of shared learning between 111 and EOC. Staff told us they would like to interact more with 111 to understand their scope and capabilities. Whilst the relationship was positive between 111 and EOC staff, staff working in EOC felt there could be more joint up ways of working to ensure a better experience for patients.

The trust complied with the National Ambulance Resilience Unit (NARU) Memorandum of understanding on the deployment of 'mutual aid'. The process of requesting or providing mutual aid was an aspect of this memorandum. The trust had good working relationships with other ambulance trusts and often sent and received 'out of area' calls from patients which required transfer to another ambulance service. Staff told us that if they received a call which was on the

border of LAS and another ambulance trust, there was never any discrepancies with which service was going to attend.

The trust collaborated with a number of private and voluntary ambulance services, patient transport services and taxi companies to provide appropriate transportation for patients. The trust had a ‘contract for the provision of taxis’ which outlined the expectations of the taxi service, eligible patient and timescales for arrival. Taxi allocations were overseen and reviewed by the CHUB to ensure the patient was suitable to use this service.

Staff told us they worked with other providers in the wider health and social care setting, such as: social services, hospitals and primary care services. There was good communication between EOC staff and external health and social care services.

We observed good working relationships between dispatchers and ambulance crews. We observed healthy discussion which was focused on best patient care.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

EOC staff gave care instructions and worsening advice provided to them via the MPDS system. CHUB staff were able to give their own clinical advice which included advice about stopping smoking, dietary and lifestyle advice and contact details for services which can support patients living with an addiction.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguard

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

The trust had a mental capacity act and consent to treatment policy. The policy provided guidance and protocols which staff were expected to understand and adhere to.

Staff received training in the Mental Capacity Act 2005 (MCA) and dementia awareness training. However, a large proportion of staff we spoke with said they would like further training in mental ill health because the current training offered by the trust was not enough to support them in carrying out their role. Staff told us their knowledge, ability and confidence were low when dealing with patients that were experiencing mental ill health. This remained the same from our previous report.

A review of the EOC risk register showed an identified risk to call handling staff staying on the line with patients threatening suicide or with challenging behaviour. Call handling staff told us they had remained on the phone with patients experiencing severe mental illness for over an hour whilst waiting for an ambulance response to attend. Staff told us this had a big impact on their own mental wellbeing.

A live module of core skills refresher training included teaching in applying the Mental Capacity Act. The trust also employed a mental health capacity lead.

The trust employed seven mental health nurses who worked on the CHUB to provide telephone advice to patients experiencing mental ill health. This nurse was also available to give advice to EOC and frontline operational staff. Despite this, four members of staff we spoke with in EOC said they would like more support when dealing with mental health callers and felt the current level of training was not sufficient enough. Staff also told us they had problems approaching the mental health nurse for advice because they were often busy or on a call and not available to be able to offer support.

Mental Capacity Act and Deprivation of Liberty Safeguards training completion rates

The trust reported that from April 2018 to March 2019 Mental Capacity Act (MCA) training was completed by 93.5% of staff in the emergency operations centre compared to the trust target of 85%.

The breakdown by staff group was as follows:

- Qualified ambulance service staff: 94.4%
- Qualified nursing staff: 93.8%
- Support to ambulance service staff: 93.5%
- NHS infrastructure support staff: 66.7%

Deprivation of Liberty Safeguards (DoLS) training

Note: The trust did not supply data for Deprivation of Liberty Safeguards (DoLS). Some trusts include DoLS training in the MCA training module.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff demonstrated compassionate, empathetic care to patients and members of the public in extremely difficult or challenging circumstances including people in mental health crisis and people caring for other who were unconscious.

Staff were provided with assertive training to enable them to take control of 999 calls to ensure that they have a fast and effective triage response to patients.

However, staff were not always calm in these situations and voices were raised when calls became exceedingly more challenging. Staff told us they found it difficult to remain polite in situations where they maybe losing control of the call. For example, where a patient or a caller was not understanding what was being asked of them or when there was a language barrier. During our inspection, we listened into a number of calls where there was difficulty obtaining clear information which caused the call handling staff to take a harsher tone and adopt a louder voice.

During our inspection we listened into a call where CPR instructions were being provided to a caller of a patient who was in cardiac arrest. The call handler was able to provide reassurance, support, care and understanding whilst controlling the situation in a professional and authoritative manner.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

We observed staff supporting callers and patients who were distressed and anxious. Staff showed understanding of the impact of their advice and used relevant support tools to aid them in their delivery of care. Staff communicated clearly and sensitively and reassured callers when help was on the way. Staff showed reassurance to callers before ending the call.

Staff showed kindness, respect and compassion for those experiencing mental ill health. Staff talked in a kind and caring manner whilst demonstrating empathy during the call.

The trust handed out awards and achievement certificates to staff who had received positive praise in the handling of a call. Staff told us this empowered them to continue to give good care and felt they gained acknowledgement regarding some of the challenging calls they have to take.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff demonstrated an understanding of the importance of involving patients, relatives and carers in their interactions. During our observations, staff always asked to speak with patients first hand where this was considered appropriate, or where not possible, would ask the caller to be by the side of the patient before triage began.

Staff communicated with patients and callers appropriately. Staff repeated information and asked callers if they understood the information being provided to them. Staff asked questions of third party callers to aid them in their triage. For example, where a patient was reported to be looking pale or flushed, call handlers asked the patients relative or carer if this was a normal complexion for them or if they looked more pale than normal.

The MPDS system had standardised advice staff were able to give callers on actions they should take whilst waiting for an ambulance. We observed this advice being given clearly and timely enough for the caller to understand.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The London Ambulance Service was the busiest ambulance trust in the UK. LAS served a population of more than eight million people in Greater London, covering an area of around 620 square miles from Heathrow in the west to Upminster in the east, and from Enfield in the north to Purley in the south. The London Ambulance Service (LAS) operated its control services function from the EOC at trust headquarters (HQ) in Waterloo and the EOC in Bow. Both sites acted as one virtual control room using computer-aided call taking and dispatch. Each control room had call-taking and dispatching functions which allowed the transfer of any sections of the operation to either site depending on the needs of the service.

The EOC received and triaged 999 calls from members of the public and other emergency services. Staff provided advice and dispatched ambulances to the scene. The EOC staff also provided assessment and treatment advice to callers who did not need an ambulance response, a service known as ‘hear and treat’. Staff gave callers advice on self-care, making an appointment

for a general practitioner (GP) or signposted callers to other services. Staff in EOC managed requests by health care professionals to convey people between hospitals or from the community into hospital.

Dispatchers were assigned a dedicated geographical area which was split into different sectors throughout London. This gave staff an understanding of the local areas such as; roads, hospitals, traffic information and liaison points.

The EOC had an incident management desk which oversaw allocation of resources to major incidents or calls requiring a large or specialist response. Staff working on this desk told us that the incident management desk was not always utilised and when it was utilised it required two members of staff which often did not happen.

The 'hear and treat' service was provided by the CHUB. Staff working here were responsible for triaging and where appropriate, giving advice so a patient could remain at home. This only happened on C3 and C4 calls (non-life threatening calls).

As reported in our last inspection report, the METDG desk was not always permanently staffed. Staff working on this desk could re-triage patients by speaking with police directly at the scene to assess whether an ambulance response was required or if referral to another service was more appropriate. Staff told us the reason for this desk not always being operational was due to staff shortages and the allocation of staff to elsewhere within EOC.

The Non-Emergency Transport Service (NETS) enabled front-line ambulances to be freed up for the sickest and most seriously injured patients and reduce delays in responding to the patients whose needs did not specifically require an ambulance. The decision to transfer calls to NETS was based on the patients' presentation at the time of the assessment and not their past medical history. NETS staff told us taxis were sometimes used by the LAS as patient transport. However, staff told us the use of a taxi was always based upon a clinical decision and a taxi would not be sent to a patient requiring emergency care. The trust's surge management plan identified the criteria for NETS suitable patients. This remained the same as in our previous inspection report.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients access services.

Staff had access to an interpreting service for callers and patients whose first language was not English. However, there was mixed response from staff on how to access and use these services. Four members of staff we spoke with had not had to use these services and said they would need management support in the eventuality they were required to use it. However, the trust provided us with data which showed the language interpretation service had been used close to 400 times per month and this was continuing to rise.

The service had 'type talk' for callers of patients who were deaf or speech impaired.

Patients received welfare calls if the ambulance response to their calls had exceeded the target time. Patients were called back and asked if any of their symptoms had changed or worsened. A new triage would be completed if answering positively to either of those questions. However, we saw evidence that welfare calls were often made outside of the target time and patients could be waiting several hours before receiving a call.

Frequent callers were identified and flagged on the system to staff. However, updating of this service was dependant on other healthcare providers updating the trust with information. Staff told us because of this, frequent callers were not always flagged up.

There was a registered mental health nurse (RMN) available within EOC to offer support to staff with mental health callers. However, the nurse was not always available, and staff told us they were often too busy to offer timely advice. The RMN was also responsible for allocating calls to the trust's mental health response car.

Access and flow

People could not always access the service when they needed it which was not in line with national standards and did not always receive the right care in a timely way.

The EOC frequently struggled to match resources to call volume. During our inspection, we observed over ten calls waiting to be answered by call handling staff. Management staff told us that the weekend prior to our inspection, they had recorded over 50 calls waiting to be answered at one stage.

Calls into the EOC were monitored at all times. Staff could see performance metrics displayed on large television screens positioned throughout the EOC. During our inspection, we saw not all calls were answered promptly and there were delays of over 30 seconds to answer a call. Staff told us this was an increasing concern of theirs as any delay in call answering could have a detrimental impact on the care and treatment of a patient.

The trust had a clinical surge management plan which was designed to ensure an appropriate response was maintained in the event of an unexpected peak in demand. Call volume was continually monitored by the trust and the duty incident delivery manager (IDM) could be contacted if patient care was considered to be compromised by a surge in call volume. A joint conference held between the IDM, gold commander, senior clinical on-call and CHUB manager was held to look at ways of alleviating pressure and drawing in extra resources. Staff we spoke with in the EOC told us they did not see any improvements as a result of the surge management plan and conveyed concern to the inspection team that demand was now often outweighing resource capability.

During our previous inspection, staff told us calls were constant and they do not get a break from it. This remained the same during this inspection, with staff telling us that demand was increasing and callers were frequently waiting longer for their calls to be answered.

Performance managers, based within EOC, were able to access a trust portal which displayed historic and live performance metrics. Data was colour coded to give staff a visual display of the length of time calls were waiting to be answered and how they were performing against trust targets. This data facilitated staff in prioritising their duties.

The emergency bed service handled safeguarding referrals. The HEMS desk was responsible for allocating and dispatching the air ambulance team and the METDG desk triaged calls from the Metropolitan Police Service. There was also an advanced paramedic desk which dispatched critical care paramedics to high acuity patients and a paramedic practitioner which dispatched staff to lower acuity patients.

There was a protocol for dispatching the hazardous area response team (HART) to calls where hazardous environments were described.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them but did not always share lessons learned with all staff.

Summary of complaints

From April 2018 to March 2019 there were 380 complaints about the emergency operations centre (37.5% of total complaints received by the trust). The trust took an average of 29 days to investigate and close complaints, this was in line with their complaints policy, which says complaints should be completed within 35 working days. A breakdown of complaints by type is below:

Complaint subject	Number of complaints	Percentage of total
Delay	169	44.5%
Conduct and behaviour	89	23.4%
Non-conveyance	71	18.7%
Communication	24	6.3%
Clinical Incident	6	1.6%
Information/Enquiries	6	1.6%
Conveyance	4	1.1%
Patient Injury or Damage to Property	3	0.8%
Treatment	3	0.8%
Explanation of Events	2	0.5%
Disputes safeguarding referral	1	0.3%
Lost Property	1	0.3%
Road handling	1	0.3%
Total	**380**	**100.0%**

Of all complaints received, 49.7% (189) were not upheld, 16.1% (61) were partially upheld and 10.0% (38) were upheld.

(Source: Trust Provider Information Request – Complaints)

Number of compliments made to the trust

Learning from experience focuses on the relationships of the chain of events that can occur between control services and sector operations (with the influence of corporate services in the background). The trust stated that they take a comprehensive approach to the analysis of situations to break down excellence to its roots to celebrate and learn from it.

(Source: Trust Provider Information Request – Compliments)

Complaints and compliments were received through a specific email facility. The team overseeing this email facility were responsible for passing compliments onto staff. There was a system for recording complaints and actions taken in response. Themes from complaints were identified and a RAG (red, amber, green) rating was applied.

The trust had a complaints and feedback policy and procedure which was due for review in March 2018. The assistant director of operations was accountable for ensuring a full and timely response to complaints and for ensuring learning outcomes were implemented.

One member of staff we spoke with said they had received a complaint relating to a call they handled and were asked to submit a written statement. However, the staff member had not received any feedback after that, despite asking their immediate line manager. The complaint

was received six months prior to our inspection.

We reviewed minutes from a 999 operations business group which showed discussion around complaints, actions requiring a response from a complaint and the owner of the complaint.

From April 2018 to March 2019 there were 51 compliments collected by the trust about the emergency operations centre (3.2% of all received trust wide).

The trust stated that the key reasons and themes of compliments received were:

- the speed of response to people who were seriously ill or injured
- the caring and compassionate attitudes towards patients and their families
- the quality of medical advice and care provided.

Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. However, staff did not always feel they understood and managed the priorities and issues the service faced. Leaders were not always visible and approachable in the service for staff.

Since our last inspection there had been an organisational restructure of staffing within EOC. Roles and responsibilities were now more aligned to job specification and staff had a greater understanding of what was expected of them, what their role entailed and who their immediate line manager was. During our engagement activity, staff told us they felt the restructure changes had not always been handled sensitively and openly and staff questioned the transparency with some of the decisions made during this time. Staff felt leaders were not as visible as they would have liked during this process. However, during the inspection, staff we spoke with were generally understanding of the need to restructure and felt the pay grades of staffing now accurately reflected the role responsibilities.

During our previous inspection, we reported staff had a level of frustration in regard to the visibility of the board. Staff told us board members visited the EOC but did not stay long or appear interested in understanding the working environment or staff concerns. During this inspection staff told us that this had not changed, and they did not feel senior management or board members had a clear understanding of the operational pressures facing EOC. Members of staff we spoke with were unable to recall the name of any board members and told us they could walk past senior leaders and not know who they were.

Staff told us they had an opportunity to attend a ‘CEO roadshow’, where the chief executive officer provided an opportunity to speak with EOC staff twice per year. However, staff told us they did not attend the CEO roadshow because they did not feel ‘there was much point’.

Managers told us there was little time to complete managerial tasks due to increased call demand and lack of available staffing. Management staff reported working extra hours to complete administrative tasks.

Staff told us they felt the executive team was constantly changing and they were unable to determine who had responsibility for which directorate. As with our previous inspection, staff reported a ‘change fatigue’ and reported they had lost interest in understanding the executive

team changes. Staff told us they felt a disconnect between front line staff and the executive team and were now unsure who held overall responsibility for both EOC's.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. However, staff did not always understand or know how to apply them and monitor progress.

There was a trust strategy 2018/19-2022/ 2023 titled 'A world class ambulance service for a world class city.' The strategy set out the trust's vision key themes**.** The trust also had a clinical strategy which covered the periods 2016/17-2022/23 and had been refreshed in 2019.

The trust had acknowledged within its strategy the need to deliver fundamental changes to its organisation's culture, capabilities and infrastructure in order to deliver the long term plan for success. EOC formed part of the trusts overall strategic plan.

Staff we spoke with told us they did not know of the trust's strategy. Staff told us they generally would not be interested in the strategy as their primary focus was upon doing their own role effectively and not being concerned with the trust's direction.

All staff received a trust induction which incorporated a session on the trust's values. The trust values were respectful, professional, innovative and collaborative.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development.

Staff told us there was an inclusive culture which accepted all beliefs, religions and faiths. Staff were observed to be wearing rainbow lanyards in support of LGBTQ+ rights. Staff told us they felt they could be themselves whilst at work and had great support and understanding from their peers and colleagues. There was a team ethic within both EOC's and staff felt they came together better at times of high demand and challenges. Staff told us it was becoming increasingly difficult to maintain the positive environment because of the staffing shortages and high staff turnover.

Staff supported one another after distressing calls and we saw evidence of colleagues checking up on one another to ensure they were ok and offer support where possible.

Staff felt the morale in EOC was positive and told us this was often the primary reason they remained in post. Staff had good relationships with frontline ambulance crews as well and we observed a 'positive banter-type conversation' between dispatch staff and ambulance crews. Staff felt this made their job more enjoyable and took away some of the stress they experience in their role.

A number of staff told us they could, ''work in a supermarket for more money and less stress'', this was also reported in our last inspection report. Staff felt the trust could do more to keep the culture positive within EOC by offering away days or social events where staff could get together outside of work to bond more with their colleagues.

Governance

Leaders did not always operate effective governance processes. Staff were clear about their roles and accountabilities but did not always have regular opportunities to meet, discuss and learn from the performance of the service.

The trust held Quality Governance and Assurance Meetings (QGAM) which provided an opportunity to review performance including ambulance response times, on-scene times and staff adherence to policies. Incidents, complaints, capacity and the risk register were also discussed and documented in meeting minutes.

Managerial staff felt the trust took governance seriously but because of operational pressures, management staff did not feel they had enough time to do exactly what was expected of them. Management staff told us they were responsible for providing senior management with actual staffing figures, call performance and any incidents. However, staff said completing these reports was timely and could take their focus away from dealing with 'day to day' duties.

Daily management meetings occurred which discussed performance and challenges within EOC. There was mixed response from management staff on who attended these meetings, actions as a result of the meetings and who was responsible for ensuring the meetings had accurate performance data to use for discussion.

Audits were carried out by the trusts quality assurance team who were responsible for feeding back call audit scores to individual members of staff. The quality assurance team would document themes from audited calls to share at the 999 operations business group. However, concerns were raised with the inspection team around recording of information from calls where a crew were blue lighting a patient into hospital. The standard process for this would be for crews to call EOC through their handheld radios and relay information to a designated non-clinical staff member within EOC, who would then forward that information onto the hospital the crew are on route too.

Staff we spoke with who were responsible for taking information from crews to pass to hospitals said they would often struggle to understand what the crew is relaying to them, especially if the crew were using medical terminology. The inspection team were told of an incident where information was handed over to the wrong hospital A&E department because the EOC call taker had misheard where the crew were taking the patient. Staff told us they used a mnemonic to take down information but even with this, they could struggle to understand what was being said. This was on the trusts EOC risk register.

Calls were audited regularly by the on-site quality assurance team. Staff spoke positively about the call audit feedback process but felt they were often unfairly scored due to the increasingly changing processes of how they triage patients. Two call handlers we spoke with told us they were marked down because they did not follow a correct process, however, they had both been on annual leave when the process was changed and therefore unaware of the changes.

There is evidence in the risk register of actions being taken and risk ratings reduced. Post inspection, the trust told us that EOC have initiated a quality governance group over the last year which reports into the Quality Oversight Group on a bi-monthly basis.

Management of risk, issues, and performance

Leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact.

The trust understood risks and the value of reporting risks on a regular basis. The trust held a monthly risk review meeting. We reviewed a number of meeting minutes which showed risks being discussed and actions for staff to follow up on.

The EOC risk register was maintained and showed an awareness of the current risks facing the service. Staff shortages were an identified risk and categorised as high with updated comments on

any actions requiring attention from this risk. Risks were discussed at the 999 operations quality group and was assigned a RAG rating. However, the risk register did not show a chronology of action taken to mitigate risks.

There was a clear audit programme to monitor the quality of the service. The trust took part in national and local audits, including benchmarking audits against other ambulance trusts. The trust also carried out a number of clinical audits to monitor the implementation of NICE guidance and used this information to identify potential learning needs within different staff groups. However, four managerial staff we spoke with said they were unaware of learning as a result of auditing and were unaware of which audits were being carried out and by whom.

Clinical staff we spoke with told us they regularly had audits carried out on their electronic documentation of patient records, this included the correct documentation of advice given to patients and where that advice had been evidenced from. The clinical staff we spoke with told us they received this information monthly and it supported them in ensuring they documented everything clearly, concisely and accurately.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required

Staff were able to access policies, protocols and other work-related information through the trusts internal intranet. However, call handling staff were unable to access the internet or their work emails on the computers they used. This meant staff needed to log onto an ‘admin computer’ of which there were not many within EOC, to access these. Staff told us this meant they often did not check their emails and may miss important information. Three members of staff told us they accessed their work email once every two weeks.

The trust had effective systems which meant information used to monitor and report quality and performance on was accurate, valid, timely and relevant.

Staff told us the mapping system used to show location of calls and where crews were, was slow, outdated and did not ‘refresh’ during times of peak demand. We observed several members of staff restarting their mapping system due to it not responding.

Engagement

Leaders and staff did not always openly engage with patients, staff, equality groups, the public and local organisations to plan and manage services.

Staff told us the trust engaged well with them during their training programme and they had opportunity to meet senior managers during this period. Staff were offered family friendly rotas and the trust supported staff in finding shift patterns which fitted around homelife and met work demands. However, staff told us that they did not always feel included in decision making relating to the EOC. Staff told us that whilst opportunities were provided to gain views on the recent staffing restructure, they felt their views were not listened to and changes went ahead despite staff having expressed some dissatisfaction with aspects of the planned restructure.

Post inspection, the trust told us that the EOC restructure was subject to a formal staff consultation exercise where they listened and considered views of staff.

The trust had a counselling service available to all staff which could be accessed via an email or telephone number. Posters for this service was displayed around the EOC and in the toilet areas.

Staff had access to link workers, specially trained staff who volunteered to offer support and advocacy to staff. Staff we spoke with who had used this service found it to be useful. Link workers received support and training to aid them in their role.

The trust had a staff recognition award scheme and we viewed certificates awarded to staff who had helped to save lives of patients over the telephone. Staff found this to be positive and a motivating factor to continue doing well in their role.

The trust worked with patient and public engagement representatives through a Trust User Group (TUG). Although, one group of public and patient representatives told us they were now no longer engaging fully with the trust as they were before. This group felt the trust was attempting to 'silence them' and were no longer interested in hearing the views of this user group.

However, post inspection, the trust told us that 15 members from the patient forum visited both EOC sites and members reported feeling well received and learnt a great deal about the operation of these centres.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The trust was piloting a mental health car which had a dedicated mental health nurse which was able to respond to callers in the South London area. A mental health nurse situated within EOC oversaw the dispatching of this car, as well offering advice and guidance to staff.

The trust conducted a programme of public visits to raise awareness of the service. This included visits to schools, public events and events with other emergency services. Staff we spoke with who attended one of these events told us it was positive and a great way of educating the public on the use of emergency services.

Emergency and urgent care

Facts and data about this service

The trust works closely with hospitals, other healthcare professionals and other emergency services. It is central to the emergency response to major incidents and terrorist threats in the capital.

As the mobile arm of the health service in London, the trust's role is to respond to emergency 999 calls, getting medical help to patients who have serious life-threatening injuries or illnesses as quickly as possible. Last year the trust attended to more than one million incidents across London.

The trust has over 5,700 staff based at ambulance stations and support offices across London. The emergency response service is split into five operational areas across London:

- north west
- north central
- north east
- south west
- south east

An assistant director of operations manages each area.

The trust has a total of 68 ambulance stations across London which, for management purposes, sit within 18F local operational areas known as group stations. Each ambulance station complex has its own local station manager.

The trust categorises calls as either category A (immediately life threatening) or category C (not serious or life threatening), refers to pre-ambulance response programme (ARP) categories. The trust aims to respond to category A calls in eight minutes and the trust will send a single responder (in a car or on a motorbike or bicycle) and a crew in an emergency ambulance. The service orders all non-life-threatening calls into one of four categories. Patients in the first two of these are expected to l be attended to by ambulance staff in either 20 or 30 minutes, depending on their condition.

(Source: Trust website www.londonambulance.nhs.uk)

A breakdown of trust vehicles by type is shown below:

Vehicle type	Number of vehicles
Fast response unit	41
A&E ambulance	29
Motorcycle response unit	8
Resus vehicle	8
Incident response officer	7
Advanced paramedic practitioner	6
First response unit	4
Cycle response unit vehicle	3

Clinical team leader	1
Medical director	1
Neonatal transfer service	1
Total	**109**

(Source: Routine Provider Information Request (RPIR) – Vehicle tab)

During the inspection, we visited eight ambulance stations and four hospital emergency departments in order to speak to staff and patients regarding the emergency and urgent care (EUC) service. We inspected ambulances and reviewed patients' clinical records. We also reviewed information provided to us prior to the inspection, during and after our visit.

Is the service safe?

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff and most staff completed it.

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training.

A breakdown of compliance for mandatory courses from April 2018 to March 2019 for all staff in emergency and urgent care is shown below:

All staff groups

Training module name	April 2018 to March 2019				
	Trained staff	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Infection prevention & control level 1 (3 years)	3,490	3,506	99.5%	85%	Yes
Medicines management (1 year)	3,221	3,269	98.5%	85%	Yes
Resuscitation level 1 (1 year)	3,448	3,506	98.3%	85%	Yes
Resuscitation level 3 adults (1 year)	3,198	3,270	97.8%	85%	Yes
Infection prevention & control level 2 (1 year)	3,310	3,398	97.4%	85%	Yes
Health, safety & welfare (3 years)	3,411	3,506	97.3%	85%	Yes
Fire safety (2 years)	3,404	3,506	97.1%	85%	Yes
Resuscitation level 2 adults (1 year)	125	129	96.9%	85%	Yes
Resuscitation level 2 paediatrics (1 year)	125	129	96.9%	85%	Yes
Medicines management (nets) (1 year)	123	128	96.1%	85%	Yes
Information governance (1 year)	3,310	3,506	94.4%	85%	Yes

EPPR incident response (clinical) (1 year)	3,203	3,398	94.3%	85%	Yes
NHS conflict resolution (3 years)	3,199	3,398	94.1%	85%	Yes
Moving & handling level 2 (people handling) (1 year)	3,160	3,398	93.0%	85%	Yes
Resuscitation level 3 paediatrics (1 year)	3,017	3,270	92.3%	85%	Yes
Resuscitation level 3 new-born (1 year)	3,017	3,270	92.3%	85%	Yes
Duty of candour (3 years)	3,188	3,506	90.9%	85%	Yes
EPPR JESIP commander e-learning (1 year)	175	193	90.7%	85%	Yes
Display screen equipment (3 years)	233	269	86.6%	85%	Yes
EPPR operational commanders (3 years)	130	156	83.3%	85%	No
Fraud awareness (no renewal)	2,684	3,506	76.6%	85%	No
Equality, diversity & human rights (3 years)	2,657	3,506	75.8%	85%	No
Moving & handling level 1 (3 years)	2,390	3,515	68.0%	85%	No

In emergency and urgent care, the 85% target was met for 19 of the 23 mandatory training modules for which staff were eligible. The service had an overall mandatory training completion rate of 91.5%, better than the trust target of 85%.

The trust provided a breakdown of mandatory training completion split by staff group. The breakdown of training compliance by training module and by staff group for staff in emergency and urgent care from April 2018 to March 2019 is shown below:

Qualified ambulance service staff:

Training module name	April 2018 to March 2019				
	Trained staff	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Resuscitation level 1 (1 year)	2,977	2,994	99.4%	85%	Yes
EPRR JESIP commander e-learning (1 year)	156	157	99.4%	85%	Yes
Resuscitation level 3 adults (1 year)	2,964	2,994	99.0%	85%	Yes
Medicines management (1 year)	2,954	2,994	98.7%	85%	Yes
Infection prevention & control level 2 (1 year)	2,951	2,994	98.6%	85%	Yes
Health, safety & welfare (3 years)	2,946	2,994	98.4%	85%	Yes
Fire safety (2 years)	2,943	2,994	98.3%	85%	Yes
Information governance (1 year)	2,892	2,994	96.6%	85%	Yes
NHS conflict resolution (3 years)	2,889	2,994	96.5%	85%	Yes
Moving & handling level 2 (people handling) (1 year)	2,859	2,994	95.5%	85%	Yes
Resuscitation level 3 new-born (1 year)	2,830	2,994	94.5%	85%	Yes
Resuscitation level 3 paediatrics (1 year)	2,830	2,994	94.5%	85%	Yes

EPRR incident response (clinical) (1 year)	2,824	2,994	94.3%	85%	Yes
Duty of candour (3 years)	2,697	2,994	90.1%	85%	Yes
EPRR operational commanders (3 years)	130	156	83.3%	85%	No
Display screen equipment (3 years)	128	157	81.5%	85%	No
Fraud awareness (no renewal)	2,211	2,994	73.8%	85%	No
Equality, diversity & human rights (3 years)	2,180	2,994	72.8%	85%	No
Moving & handling level 1 (3 years)	1,946	3,003	64.8%	85%	No

In emergency and urgent care met the 85% target was met for 14 of the 19 mandatory training modules for which qualified ambulance service staff were eligible. Qualified ambulance service staff had an overall mandatory training completion rate of 91.6%, better than the trust target of 85%.

Support to ambulance service staff:

Training module name	April 2018 to March 2019				
	Trained staff	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Resuscitation level 2 adults (1 year)	125	128	97.7%	85%	Yes
Resuscitation level 2 paediatrics (1 year)	125	128	97.7%	85%	Yes
Infection prevention & control level 1 (3 years)	457	469	97.4%	85%	Yes
Medicines management (1 year)	267	275	97.1%	85%	Yes
Medicines management (nets) (1 year)	123	128	96.1%	85%	Yes
Duty of candour (3 years)	450	469	95.9%	85%	Yes
Equality, diversity & human rights (3 years)	440	469	93.8%	85%	Yes
EPPR incident response (clinical) (1 year)	378	403	93.8%	85%	Yes
Resuscitation level 1 (1 year)	436	469	93.0%	85%	Yes
Display screen equipment (3 years)	64	69	92.8%	85%	Yes
Fraud awareness (no renewal)	432	469	92.1%	85%	Yes
Health, safety & welfare (3 years)	431	469	91.9%	85%	Yes
Fire safety (2 years)	423	469	90.2%	85%	Yes
Infection prevention & control level 2 (1 year)	358	403	88.8%	85%	Yes
Moving & handling level 1 (3 years)	414	469	88.3%	85%	Yes
Resuscitation level 3 adults (1 year)	234	275	85.1%	85%	Yes
Information governance (1 year)	382	469	81.4%	85%	No
NHS conflict resolution (3 years)	309	403	76.7%	85%	No
Moving & handling level 2 (people handling) (1 year)	300	403	74.4%	85%	No
Resuscitation level 3 paediatrics (1 year)	187	275	68.0%	85%	No
Resuscitation level 3 new-born (1 year)	187	275	68.0%	85%	No

In emergency and urgent care, the 85% target was met for 16 of the 21 mandatory training

modules for which support to ambulance service staff were eligible. Support to ambulance service staff had an overall mandatory training completion rate of 88.3%, better than the trust target of 85%.

NHS infrastructure support staff:

Training module name	April 2018 to March 2019				
	Trained staff	Eligible staff	Completion rate	Trust target	Met (Yes/No)
NHS conflict resolution (3 years)	1	1	100.0%	85%	Yes
Moving & handling level 2 (people handling) (1 year)	1	1	100.0%	85%	Yes
EPRR incident response (clinical) (1 year)	1	1	100.0%	85%	Yes
Infection prevention & control level 2 (1 year)	1	1	100.0%	85%	Yes
Duty of candour (3 years)	41	43	95.3%	85%	Yes
Fraud awareness (no renewal)	41	43	95.3%	85%	Yes
Display screen equipment (3 years)	41	43	95.3%	85%	Yes
Infection prevention & control level 1 (3 years)	40	43	93.0%	85%	Yes
Fire safety (2 years)	38	43	88.4%	85%	Yes
Equality, diversity & human rights (3 years)	37	43	86.0%	85%	Yes
Information governance (1 year)	36	43	83.7%	85%	No
Resuscitation level 1 (1 year)	35	43	81.4%	85%	No
Health, safety & welfare (3 years)	34	43	79.1%	85%	No
Moving & handling level 1 (3 years)	30	43	69.8%	85%	No
EPRR JESIP commander e-learning (1 year)	19	36	52.8%	85%	No
Resuscitation level 2 adults (1 year)	0	1	0.0%	85%	No
Resuscitation level 3 new born (1 year)	0	1	0.0%	85%	No
Resuscitation level 2 paediatrics (1 year)	0	1	0.0%	85%	No
Resuscitation level 3 adults (1 year)	0	1	0.0%	85%	No
Resuscitation level 3 paediatrics (1 year)	0	1	0.0%	85%	No

In emergency and urgent care, the 85% target was met for 10 of the 20 mandatory training modules for which NHS infrastructure support staff were eligible.

NHS infrastructure support staff had an overall mandatory training completion rate of 83.4%, below the trust target of 85%. However, care should be taken when interpreting completion rates due to small numbers of eligible staff for some modules.

(Source: Trust Provider Information Request – Mandatory training)

Mandatory training was completed through a variety of methods including e-learning modules or through classroom-based teaching sessions.

As we reported during our previous inspection 2018, staff had three days protected training time built into their rotas, which enabled them the time to complete the required training.

Staff we spoke with told us that they attended core-skills refresher (CSR) classroom-based training as well as undertaking eLearning course. E-learning could be undertaken at the staff member's home or in the station using one of the computers which the service provided for staff to use.

During our previous inspection, staff told us the electronic staff record (ESR) used for accessing training was sometimes unreliable. For example, passwords sometimes expired, or they had difficult accessing at times. Staff we spoke with on this inspection told us that this had not improved. The system was frequently taken down for updating or maintenance at weekend and evening which was when they were likely to want to complete their e-learning modules. However, since the inspection the trust provided us with the following information. The trust switched to electronic payslips which increased the frequency of when staff log into ESR. Of 6101 employees employed by the trust, 99.2% had successfully logged into ESR at least once, with 92% logging in in the 90 days prior to the inspection and 75.3% logging on in the 30 days prior to the inspection.

The trust had introduced a new role since our last inspection. This was the role of clinical team managers. Clinical team managers replaced the previous role of clinical team leader. The new clinical team manager role had a wider remit which included a greater role in disciplinary processes and monitoring of mandatory training.

The trust had completed a root and branch independent training review. This was a review of training provision across the organisation. As a result of the review a number of recommendations were made for example the trust developed an overarching training and education strategy which would be informed by the trust's organisational strategy and strategies in addition to developments in the healthcare system relevant to an education offer.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

As we reported during the previous inspection, safeguarding training was delivered to staff in a variety of methods. All new starters to the organisation received information on safeguarding during their induction training. Safeguarding level 1 training was e-learning for all non-clinical staff (3 yearly), with a yearly safeguarding update of two hours at level 2. Level 3 training for key staff was a full day's face to face training, which included talking through cases and scenarios. The specialist safeguarding team had external training at levels 4 and 5.

Since our last inspection the process for make a safeguarding referral had changed. Staff wishing to make a safeguarding referral for a vulnerable adult or child rang the emergency beds service (EBS), where a member of staff took the information from the ambulance crews and made the referral to the relevant safeguarding authority. This service was available 24 hours per day, seven days per week. During busy times the service may not be able to immediately take the referral from the crews, but they would call the crew member back when they had availability. This did mean that the crew were unable to return to duty and be ready to attend another patient until they had completed the referral call. Crews we spoke with reported they could wait up to an hour for a call back at busy times. During one of our observations, we saw the EBS service ring back to take a safeguarding referral for a child within 20 minutes of the crew contacting the service.

The safeguarding team had increased from six to 12 key members led by person, who also had a deputy chair role on the National Ambulance Safeguarding Group.

The plan was now to facilitate the attendance of safeguarding leads at the chief executive officer's (CEO) roadshows.

A three-year target had been set for all front-line staff to complete safeguarding level three as per the Intercollegiate documents for safeguarding for adults and children, and this had been agreed by commissioners. The trust was going beyond the intercollegiate document and aiming to train all frontline staff, regardless of being a paramedic to the gold standard. The London Ambulance Service was the only trust doing this thus far.

Safeguarding certificates had been created to recognise and reward staff, and the trust had also recently introduced safeguarding star badges. These were to be awarded on merit, based on a presentation of a particular case and its consideration by a panel.

Clinical staff had safeguarding training updates within the core skills refresher (CSR) training.

During the inspection we were shown safeguarding pens which had been given to all staff, the pens had a scroll out details which had information on safeguarding and mental capacity which was easily accessible for staff to refer to. However, we did not see staff using these pens when we were on the inspection.

We were shown a copy of a small safeguarding handbook, 2018 edition, which included detailed information on both adults and children at risk, such as the referral process and assessing capacity. During the inspection we observed staff making safeguarding referrals and we did not see those staff use these books.

We were shown Twiddle Mitts, which were knitted and sewn by a not for profit organisation. We were told these Twiddle Mitts were accessible on all vehicles and enabled individuals with needs associated with dementia to have a tactile aid to help reduce any anxiety. We did not however, see any of these Twiddle Mitts in use on any of the ambulances inspected however, the patients being treated during our observations did not require the use of Twiddle Mitts. We were told the London ambulance service were the only trust to have these on all vehicles. The Twiddle Mitts were single use and packaged to avoid contamination issues.

September was National Ambulance Safeguarding month, and the deputy chair of the National Ambulance Safeguarding Group had been instrumental in introducing this. Topics covered during the month included; domestic abuse, mental capacity act, and looked after children.

Safeguarding training completion rates

The table below includes prevent training as a safeguarding course. Prevent works to stop individuals from getting involved or supporting terrorism or extremist activity.

The trust set a target of 85% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses from April 2018 to March 2019 for all staff in emergency and urgent care is shown below:

All staff groups

Training module name	April 2018 to March 2019

	Eligible staff	Trained staff	Completion rate	Trust target	Met (Yes/No)
Prevent level 1 (3 years)	3,506	3,471	99.0%	85%	Yes
Safeguarding adults & children level 1 (3 years)	3,506	3,482	99.3%	85%	Yes
Safeguarding adults & children level 2 (clinical) (1 year)	3,398	3,346	98.5%	85%	Yes
Prevent level 2 (3 years)	3,398	3,288	96.8%	85%	Yes

In emergency and urgent care, the 85% target was met for all safeguarding training modules for which staff were eligible. The service had an overall safeguarding training completion rate of 98.4%, better than the trust target of 85%.

The trust provided a breakdown of safeguarding training completion split by staff group. The breakdown of training compliance by training module and by staff group for staff in emergency and urgent care from April 2018 to March 2019 is below:

Qualified ambulance service staff:

Training module name	April 2018 to March 2019				
	Eligible staff	Trained staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults & Children Level 1 (3 Years)	2,994	2,993	100.0%	85%	Yes
Prevent Level 1 (3 Years)	2,994	2,979	99.5%	85%	Yes
Prevent Level 2 (3 Years)	2,994	2,968	99.1%	85%	Yes
Safeguarding Adults & Children Level 2 (Clinical) (1 Year)	2,994	2,952	98.6%	85%	Yes

In emergency and urgent care, the 85% target was met for the four safeguarding training modules for which qualified ambulance service staff were eligible. Qualified ambulance service staff had an overall safeguarding training completion rate of 99.3%, better than the trust target of 85%.

Support to ambulance service staff:

Training module name	April 2018 to March 2019				
	Eligible staff	Trained staff	Completion rate	Trust target	Met (Yes/No)
Prevent Level 1 (3 Years)	469	449	95.7%	85%	Yes
Safeguarding Adults & Children Level 2 (Clinical) (1 Year)	403	393	97.5%	85%	Yes
Safeguarding Adults & Children Level 1 (3 Years)	469	453	96.6%	85%	Yes
Prevent Level 2 (3 Years)	403	319	79.2%	85%	No

In emergency and urgent care, the 85% target was met for three of the four safeguarding training modules for which support to ambulance service staff were eligible. Support to ambulance service staff had an overall safeguarding training completion rate of 95.2%, better than the trust target of 85%.

NHS infrastructure support staff:

Training module name	April 2018 to March 2019				
	Eligible staff	Trained staff	Completion rate	Trust target	Met (Yes/No)
Prevent level 1 (3 years)	43	43	100.0%	85%	Yes
Prevent level 2 (3 years)	1	1	100.0%	85%	Yes
Safeguarding adults & children level 2 (clinical) (1 year)	1	1	100.0%	85%	Yes
Safeguarding adults & children level 1 (3 years)	43	36	83.7%	85%	No

In emergency and urgent care, the 85% target was met for three of the four safeguarding training modules for which NHS infrastructure support staff were eligible.

Support to ambulance service staff had an overall safeguarding training completion rate of 92.0%, better than the trust target of 85%. However, care should be taken when interpreting completion rates due to small numbers of eligible staff for some modules

(Source: Trust Provider Information Request – Mandatory training)

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and premises visibly clean.

All the vehicles we inspected were visibly clean, tidy and well stocked. We saw records which confirmed the vehicles had been cleaned and re-stocked daily, and that they had a six weekly deep cleans. During the deep clean, staff told us that all equipment was removed, cleaned and checked. We asked the make ready teams about how they managed the decontamination of an ambulance which had transported a contagious patient. They told us they deep cleaned the ambulances when this circumstance arose, however, they were not able to confirm that the ambulances were swabbed post deep clean to ensure there was no residual risk.

Vehicles had hand cleansing and decontamination wipes available. Infection prevention and control (IPC) measures were in place to ensure patients were protected against healthcare-acquired infections whilst on the ambulances.

All staff we saw wore appropriate workwear and uniforms. All staff decontaminated their hands immediately before and after every episode of patient care or direct care. Correct personal protective equipment (PPE) was worn and staff had a clear understanding of when PPE should be

worn. We observed all ambulance staff adhering to the principles of ‘bare below the elbow’ to minimise cross infection.

Staff had access to spare linen on the vehicle and could re-stock their vehicle with linen from emergency departments (EDs) they visited during their shift. We observed staff cleaning stretchers and equipment with disinfectant wipes after handing over their patient to ED staff and refreshing linen stocks.

The trust contracted a service to make ready the vehicles. The make ready service cleaned, prepared and replenished stock in ambulance and rapid response vehicles. Check lists were used to ensure the make ready teams checked each vehicle and its equipment appropriately.

Infection prevention and control posters were displayed in the stations to remind staff of the various requirements including disposal of waste.

Cleaning schedules were displayed in the stations we visited. Different coloured cloths were used to clean the inside and outside of the vehicles and disposable mop heads were used to reduce the risk of spreading infection. In all the stations we visited we saw cleaning products were stored securely and in line with the Control of Substances Hazardous to Health (COSHH) requirements.

The stations had coloured waste bins which were provided in order for staff to separate waste according to type, for example general waste from soiled waste. Waste bins, including the sharps bin, were kept locked to prevent unauthorised access. Clinical waste was collected regularly from stations.

In the staff changing areas we saw cleaning records on display that showed toilet and shower facilities were cleaned daily.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment did not always keep people and equipment safe. Staff were not always trained to use them. Staff managed clinical waste well. However, we found issues with security at some of the stations visited.

We visited eight stations during the inspection. Of the eight stations we visited we were able to walk freely into two of those stations through open doors without being challenged by staff or in one case by a security guard who was in an office. We were challenged in one station by staff who spotted us after we had started to walk around the premises. The other stations were secure with electronic coded key pad entry. There was a locked key safe for vehicle keys at the stations. We found seven ambulances and four rapid response vehicles that were unlocked in ambulance stations or parked outside a station on a public access road, (one ambulance was complete with Entonox gas and full lifepak 15 (used to monitor patient vital signs and defibrillator). We were not assured that security was sufficient to ensure equipment and vehicles could not be taken by unauthorised people.

We also saw 10 ambulances parked outside the emergency departments at hospitals which had been were left open and unattended (did not see any keys or medicines left unattended.) Staff confirmed they were not emergency calls when they had arrived at the ED.

The trust provided us with the following information regarding security at stations. The trust's health, safety & security team undertook a series of phase two 'mystery shopper' visits during June 2019 to review standards of security arrangements at ambulance stations. Average trust-wide security compliance in February 2019 had been 63% (phase 1), which had risen to 81% in June 2019 (phase 2). In February 2019, the number of sites that achieved a compliance of 80% or over was eight out of 70 stations. In June 2019, this had improved to 52 out of 70 stations achieved compliance of 80% or over.

Following the inspection , when the concerns regarding security of stations and unlocked vehicles was highlighted to the trust, the trust provided us with information regarding a campaign that the chief executive office had led entitled 'ok to challenge'. The trust also instigated a twice daily vehicle check for the vehicles parked in the roads around the trust head quarters and waterloo ambulance station, which if an unlocked vehicle was discovered would be reported as an incident and the staff responsible would be spoken to by their manager.

We met with 12 members of the ambulance fleet team. The fleet team were responsible for all maintenance and servicing of vehicles. The fleet team expressed concerns regarding the lack of training they have received in the new type of ambulance vehicle that were now being used by the service. They also expressed concern about the length of time that it now took following a change to the process to have a vehicle repaired following an accident. Vehicles could be off the road for long periods of time waiting estimates for costs of repair. This put added pressure on the use of other vehicle stock, which had at times gone passed servicing dates to ensure the levels of vehicles required on the road were available.

We found of the 29 sharps bins we checked in ambulances or in paramedic kit bags that 23 did not have a date of assembly or was dated and did not have a date they should have been replaced by.

We checked eight suction machines on ambulances we inspected and found four had not been calibrated.

We checked 17 defibrillator and electro cardio graph units and found four contained at least one out of date pad, some by a few days but others were out of date by 18 months. The pads dry out after their use by date and could be infective when used past this date.

All the staff we spoke with told us that paediatric pulse oximeters SATS probes (used to check oxygen saturation levels and heart rate) were very hard to find and they did not have one in the ambulance on the majority of shifts they worked.

There were provisions on all of the ambulances we observed for the conveying of children. Children's harnesses were available in all the ambulances we observed. However, there were no multiway harnesses for adults on any for the ambulances we observed. The stretchers were fitted with additional straps to ensure patient safety during transfer.

The make ready centres cleaned and replenished equipment. This included all disposable equipment and medical supplies. Staff told us when they were able, they gathered additional or used equipment from the stores within the station if they ran short or found something missing when they did their checks.

Staff told us they had 10 minutes to make their ambulances ready, once they had logged on for a shift. This included check the roadworthiness of the vehicles and the equipment within the ambulance. If staff found there were missing items or equipment, they reported the missing equipment to the central support unit who would check the rest of the service for availability of the missing equipment and had a commitment to getting back to the crew within two hours. Crews told

us that this did not always happen, and they usually had to make a second call after two hours to chase the availability of missing equipment.

Ambulances were stocked with different types of lifting cushions, traditional carry chairs and tracked chairs. We observed staff using seatbelts in the back of ambulance vehicles to keep patients secure through their journey. On one of the ambulances we spent time on did not have a lifting cushion. The crew had reporting that it was missing from the stock when they started their shift, but none could be found. During the shift we observed they had to physically lift a patient from the floor, this risked injury to the crew and went against the trust's own manual handling policy.

We completed six vehicles observation checklists throughout the inspection. We found all vehicles had radios and satellite navigation systems. All batteries for equipment were charged and all emergency equipment was available including defibrillators and monitor, oxygen and suction. However, on two out of the six vehicles the defibrillators had not been checked and on all the ambulances checked we noted they did not have an appropriate oxygen saturation probe for babies or EZIOs (which is an intraosseous infusion system used for injecting directly into the marrow of the bone). Both of these pieces of equipment crews reported were rarely if ever available and this had been the case for long time. Following the inspection the trust confirmed they had ordered 100 new oxygen saturation probes for babies which would be cabled tied to the lifepak15 to try to prevent them being mislaid.

We observed the stock rooms in the stations we visited and found them all to be tidy, uncluttered with equipment and consumables being stored appropriately and off the ground, limiting the risk of contamination.

10 members of staff told us that, overall satellite navigations were fit for purpose, but they were not regularly updated and could take vehicles to the wrong address, which contributed to further delays in reaching patients.

At all of the stations we visited we found a fully equipped training room. The stations had a room or space within the mess room for desktop computers. This allowed staff to attend in their own time to complete training or university work.

The service has been working to test and introduce environmentally friend vehicles to their fleet. The trust had looked at opportunities to introduce electric and hybrid vehicles. The trust were at present testing an electric car for use by specialist staff. The trust's motor cycle response team had also trialled a zero emissions motor bike.

The service had also deployed 20 fully electric vehicles into the fleet which were being used by LGMs.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used their training and clinical judgement to assess the patients' condition. We saw crews carry out observations and assessments of patients using Joint Royal Colleges Ambulance Liaison Committee (UK) (JRCALC) protocols. Staff had access to the latest version JRCALC via an application on their personal electronic devices or a small pocket sizes guide was carried by some

crews. Staff had access to care pathways which provided guidance on the most appropriate action to take when managing patients' presenting symptoms.

Patients in the care of staff were monitored using the national early warning scoring system (NEWS2). NEWS2 is based on a simple scoring system in which a score is allocated to six physiological measurements already taken in hospitals such as respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness. Staff used NEWS2 to detect signs of deterioration during their assessments. Staff had good understanding of assessing and responding to sepsis markers.

Ambulance crews had access to additional clinical support via the clinical hub. Calls to the clinical hub were taken by staff with additional training and skills, including doctors Midwives and mental health nurses. Staff confirmed they could call the clinical hub while on scene with a patient and we observed them doing so; however, there were times when they could not get through the clinical advisors as they were busy taking other calls. The crews then had to wait for a call back.

The service used community first responders to support their service. These were volunteers trained by the service to respond to emergencies quickly while an ambulance or other response was en-route to the scene. We saw defined criteria regarding the type of call these volunteers could be sent to attend. The volunteers had clear parameters in which they could work.

During our observations of care, we mostly saw appropriate manual handling techniques used for the transfer of all patients. This ensured that staff and patient safety was maintained, and injuries avoided.

Out of hours escalation process for staff was displayed in the stations we visited. Staff told us that they could contact the police for assistance when responding to calls with a patient suffering a mental health crisis. We went out with the mental health joint response car with crews to attend calls to patient suffering mental ill health who had called an ambulance. During this observation we found the team to work to ensure the patient did not have to attend the ED but arranged for the patient with their consent to be admitted directly to an inpatient mental health bed.

Flagging systems were in place on the electronic system to inform staff of patients with additional risks. This included but was not limited to patients suffering from mental health illness, learning disabilities and those with high risks of violence and aggression. Staff said they could access additional information or support from external agencies; including the police. Staff knew how to manage difficult and aggressive situations.

We observed patients receiving continuous monitoring whilst on route to hospital. We saw staff continuously reassessing patients when their condition deteriorated. Staff effectively handed over patients to the care of the emergency departments in acute hospitals. Handover information included patients' medical history, current medicines, present condition, clinical observations, using the NEWS2 tool and any known allergies.

Staff told us at times there were delays at certain acute hospitals. The delays were around patients being admitted and handed over to clinical staff at the emergency department. Whilst we were on the inspection observing care provided by the ambulance service, we did not see any delayed handovers or crews waiting in corridors to handover their patients at the hospitals we visited.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.

Staffing levels were sufficient to meet the current planned levels and populate the current rotas. Frontline staff told us they were tired and felt as if they were going from job to job with very little downtime. Managers confirmed what frontline staff told us.

As we reported in our previous inspection, the revised rest break policy was implemented in December 2017, which introduced the option for staff to take a flexible break at a location of their choice. Most staff told us they didn't get breaks, but they weren't always unhappy regarding this as they preferred to finish on time and if they took a rest break, their protected 30 minute at the end of their shift would not apply. Information provided by the trust shows the percentage ambulances which received a break and then subsequently finish late was averaging at 28% compared to a pre-pilot average of 77.5%. However, the trust did not state over which period of time this statistic demonstrates.

Staff gave a fairly unanimously negative opinion of the trust's sickness policy, which was the same as we found at our previous inspection. The majority of staff we spoke with said they felt pressured to come back to work and some were frightened to take any time off. A small number said they felt that those staff who had regular sickness or patterns of sickness were managed well and apparent concerns or problems were addressed.

We spoke with some local station managers and clinical team managers who told us they would use a welfare call to talk to staff whilst they were off sick. They had discretion with regard to when, how often and the length of time between calls. Despite us being informed by the trust of the range of supportive systems in place, eight out of 10 staff we spoke with raised concerns about the level of well-being support for stress, musculoskeletal issues and bereavement which was offered by the service. They felt there had been a decline in the level of support and the speed at which you could access support but felt that this had started to improve over recent months due to a change of the service contracted to provide the support services.

In addition to the frontline ambulances, the service utilised fast response units (FSU) as an available resource. FSU's were single crewed vehicles which were deployed, as per the service's operating model. These FSU could be staffed by paramedics or emergency medical technicians.

Staff we spoke with told us they sometimes finished their shifts late because of the high demands of the service. Staff appeared to be understanding and accepting of this and saw it as an 'occupational hazard'. Staff were paid overtime payments when this occurred.

The service told us they were always recruiting for paramedics with international recruitment still continuing. They were recruiting internally for clinical team managers as some stations we visited we short of clinical team managers. This put pressure on the existing clinical team managers as they had larger teams to manage than they would generally have.

As we found during our last inspection, staff continued to be happy with their rotas. We spoke with staff that worked part time or adjusted rotas to fit round child care or caring commitments. They told us they were happy with the rota they had agreed locally.

At one of the stations we visited we were told there was 12% vacancy rate for paramedic crew but that 10 new staff were due to start in October 2019. The local station manager said they had escalated staffing to the risk register and trust had been quick to address this and recruit new staff.

Planned vs actual

The trust has reported their staffing numbers below for emergency and urgent care as at March 2018 and March 2019. Add commentary.

Staff Group	As at March 2018			As at March 2019		
	Planned staff - WTE	**Actual staff WTE staff**	**Fill rate**	**Planned WTE staff**	**Actual WTE staff**	**Fill rate**
Qualified ambulance service staff	2,901.4	2,934.7	101.1%	3,176.5	2,987.9	94.1%
Support to ambulance service staff	616.7	313.5	50.8%	352.5	318.5	90.4%
NHS infrastructure support	47.0	45.0	95.7%	45.4	41.3	91.1%
Total	**3,565.2**	**3,293.3**	**92.4%**	**3,574.3**	**3,347.7**	**93.7%**

Fill rates for qualified ambulance service staff decreased from 101.1% in March 2018 to 94.1% in March 2019. While the service had an increase of 53.2 whole-time equivalent (WTE) actual staff, there was a greater increase of 275.1 WTE planned staff from March 2018 to March 2019, which contributed to the decline in fill rates.

Fill rates for support to ambulance service staff increased from 50.8% in March 2018 to 90.4% in March 2019. The actual decrease of five WTE staff compared to the decrease of 264.3 WTE planned staff, which contributed to the increase in fill rates.

Fill rates for NHS infrastructure support staff decreased from 95.7% in March 2018 to 91.1% in March 2019. The actual decrease of 3.7 WTE staff compared to the decrease of 1.7 WTE planned staff, which contributed to the decrease in fill rates.

(Source: Trust Routine Provider Information Request– Total staffing)

Vacancy rates

From April 2018 to March 2019 the trust reported an annual vacancy rate of 4.0% for emergency and urgent care. The trust target vacancy rate was less than 5%.

The service overall met the trust target. However, only qualified ambulance service staff had a vacancy rate lower than the trust target. NHS infrastructure support staff and support to ambulance service staff had vacancy rates above the trust target.

A breakdown of vacancy rates by staff group is below:

- Qualified ambulance service staff: 2.9%
- Support to ambulance service staff: 9.2%
- NHS infrastructure support staff: 16.8%

(Source: Trust Routine Provider Information Request– Vacancy)

Turnover

From April 2018 to March 2019 the trust reported an annual turnover rate of 10.5% for emergency and urgent care. The trust target turnover rate was less than 10%. The service overall did not meet the trust target.

A breakdown of turnover rates by staff group is below:

- Qualified ambulance service staff: 10.7%
- Support to ambulance service staff: 9.1%
- NHS infrastructure support staff: 10.9%

(Source: Trust Routine Provider Information Request– Turnover)

Sickness

From April 2018 to March 2019 the trust reported an annual sickness rate of 5.7% for emergency and urgent care. The trust target sickness rate was less than 5%.

A breakdown of sickness rates by staff group is below:

- Qualified ambulance service staff: 5.9%
- Support to ambulance service staff: 4.2%
- NHS infrastructure support staff: 3.9%

(Source: Trust Routine Provider Information Request– Sickness)

Nursing and medical bank and agency/locum staff usage

From April 2018 to March 2019 bank staff covered 1.6% of the total qualified ambulance service staff hours in emergency and urgent care.

The service did not report any agency staff usage. However, bank or agency staff did not fill 12.7% of hours to cover staff absence.

(Source: Trust Provider Information Request – Bank agency locum tab)

Temporary staff usage

From April 2018 to March 2019 the service did not report any temporary staff usage.

(Source: Trust Provider Information Request – Temp staff tab)

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

As we reported during our last inspection, patient record forms (PRF) were completed in paper format for each patient. These forms were completed in duplicate using carbon paper, enabling a

copy to be provided to the ED at handover. Patient's medical history, symptoms, and observations including blood pressure, blood sugar levels, respiration rate, temperature, and medications given were recorded.

When completed the PRFs were stored in brown envelopes with the staff in the front of the ambulance. As we reported during our last inspection all of the PRFs we viewed were clearly written and well completed, with all relevant information being included.

PRFs were sealed in brown envelopes and placed in locked secure boxes in the ambulance station at the end of the shift. They were removed each morning and scanned into the electronic patient record.

The trust had a clinical audit programme that focused on both national and local areas of priority. The trust continually audited the patient report forms (PRFs) for patients who presented with the following eight conditions: cardiac arrest, ST-elevation myocardial infarction (STEMI), stroke, major trauma, difficulty in breathing, glycaemic emergencies, mental health, and severe sepsis. There were a further nine local clinical audits for areas such as end of life, spinal injuries and maternity emergencies.

Oversight of documentation was still completed by the local station managers through the monthly sector clinical performance indicators reports. These reports provided audited feedback on documentation of medicine management and clinical aspects of care.

Frontline staff were able to use electronic tablets to log into Co-ordinate my care to see general practitioner records for specific patients when on route to them. When staff in the emergency operations centres (EOC) had access to information, such as end of life care or a patient's preference regarding 'do not attempt cardio pulmonary resuscitation' decisions (DNACPRs), they would alert ambulance staff to this information.

Medicines

The service used systems and processes to safely diagnose, then treat with, administer, record and store medicines. However, there were some areas which needed improvements. Clinical team managers carried out daily audits of medicines held on site, including used medicines bags, morphine registers and diazepam use.

Both stations visited by the medicines inspection team had a new medicines rooms, which had been introduced approximately 12-18 months ago. These had enhanced security measures. Staff had a key to the medicines room, but it had to be activated by entering their personnel PIN into the system. Based on their role it would only provide access for a certain length of time. The controlled drugs cupboards were locked and had restricted access. The medicines rooms were temperature controlled and had CCTV. All medicines kits were trackable and required scanning out/in using the digital barcode system. Codes to the medicine rooms were changed regularly, or within 24hrs if used by a staff member to gain access without their key.

Ambulance staff were trained to diagnose and treat people with medicines utilising national ambulance service clinical guidelines. Patient group direction (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment) were used to increase the range of medicines paramedics could use to treat people. Whilst, those we were shown had past their review dates, staff explained how the risks were managed and the programme to review, update and re-issue these PGDs was progressing. Following incidents involving incorrect administration of IV fluids, the trust now stocked the two different fluids in different containers to reduce the risk of miss selection.

Staff informed us that they explained to patients what medicines they were administering to them. Staff explained that they advised patients to purchase over the counter medicines for pain relief, indigestion or allergic reactions. They would also recommend patients sought further advice from a community pharmacist or their GP when appropriate.

Medicines were stored securely. All medicines including controlled drugs were centrally purchased. Medical gases were delivered to specific ambulance stations by the manufacturer in line with an agreed schedule. Tamper evident medicine bags were prepacked centrally. These bags and other medicines were distributed via a top up service. Used bags were collected and replaced with replenished sealed bags.

Since the last inspection in March 2018, more stations had been installed with purpose-built medicines storage rooms. Medicines at these stations were temperature monitored and within the required temperature ranges. However, medicines storage temperatures were not monitored at other stations.

Ambulance staff were responsible for ensuring the correct medicines were on the vehicle before they started their shift. Out of date medicines were collected by the top-up service and disposed of appropriately. However, we found some medicines in vehicles were out of date and some medicines did not have opening dates annotated on them. Therefore, there was a risk medicines may be administered to patients past their expiry date. There was a risk that incorrect and out of date medicines could be given to patients. Staff explained they were intending to pilot then introduce an additional tamper evident medicine bag for these medicines, however this project was on hold pending the completion of the medicines storage room and electronic tracking tool projects.

Staff explained how they tracked medicines with an electronic tracking tool. However, staff were concerned that records for medicines stock were not always up to date, due to variations in computer connectivity. Senior staff members who used the medicines were able to amend the stock quantity, which meant the system to manage and track usage of medicines may not always be effective.

A pilot study had been undertaken allowing ambulance staff access to patients' summary care records (SCR is a summary of NHS patient data on an electronic patient record). Following the success of the pilot, plans were being developed to roll out access to records of all patients across the trust. Ambulances carried a sealable bag for patients' property including medicines.

Medicines and equipment alerts were centrally received, reviewed and acted on or information shared with staff via newsletters and clinical briefings. When the PGDs were reviewed and republished the new versions included links the MHRA yellow card system for reporting concerns with medicines and medical devices. There was an electronic system to report and investigate medicines related errors. Incidences were investigated, and learning was shared across the trust.

Paramedics and emergency medical technicians visiting patients had access to a pre-authorised medicines stock. They did not prescribe medicines. This provided assurance that medicines were being used appropriately.

Safety performance

The service used monitoring results well to improve safety. Staff collected safety information and made it publicly available.

There was an escalation process in place for seriously ill patients, this involved the EOC pre-alerting the emergency department clinicians. Escalation plans were in place at the stations which

details other providers who would be involved, these included NHS England, and other agreed health care providers.

As we reported during our previous inspection staff told us they had received major incident training as part of their core skills refresher training.

Business continuity management identified and mitigated risk and disruptions that could affect the performance of the organisation.

The planning for the winter pressure was as we reported during our previous inspection. The trust was working on robust winter plans. Throughout winter period the trust would be producing weekly briefing document. This would be shared with external stakeholders and provide details on predicted demand for the week ahead, demand level, upcoming events, weather related concerns, hospital handover delays and an update on infection control conditions.

Each vehicle contained action cards and patient priority tags and it was the responsibility of the make ready team to place these on each vehicle. Major incident vehicles were available, stocked and ready for use in an event of a major incident.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team, the wider service and partner organisations. When things went wrong, staff apologised and gave patients honest information and suitable support.

As we had reported during our previous inspection, staff told us there was a healthy incident reporting culture within the service now. Self-reporting of incidents involving staff and colleagues was said to have got better, and confidence continued to grow in relation to the value of reporting issues and a willingness to come forward. Staff told us there was a more transparent response from incident reporting and learning as a result.

Incidents could be reported 24 hours a day during their shift by calling a dedicated telephone line manned by staff in the EOC or by directly inputting details onto the online reporting system when they returned to the station. The personal electronic devices each staff member had been issued with still did not have the capability for reporting incident. Staff reported that this would be very useful to them when it becomes available.

Staff knew how to report incidents and they understood their responsibilities to raise concerns, reports incidents and near misses. Staff gave examples of when something went wrong, investigations were conducted, and lessons were learnt. Staff gave us examples of incidents that had been reported, such as, vehicle and equipment failure, staff accident and injury.

Staff said they received feedback from incidents they had reported from their manager and found out about learning from trust-wide incidents via email and news bulletins.

Managers told us the number of incidents around medicines had increased but this reflected increased staff vigilance and awareness following issues around medicines security and safety alerts. Staff told us about an incident where a patient had been given the incorrect dose of adrenaline and the trust had introduced a safety campaign in response, ‘Remember IM adrenaline’.

Trust safety messages were displayed on the vehicle resource centre screens in the staff mess rooms in the stations we visited.

As we reported during our previous inspection, staff we spoke with were aware of their responsibility around duty of candour (DoC). DoC is a regulatory duty that relates to 'openness', 'honesty' and 'transparency' and requires providers of health and social care services to notify patients or other relevant person(s) of certain notifiable safety incidents and provide reasonable support to that person.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From May 2018 to May 2019 the trust reported no incidents classified as never events for emergency and urgent care services.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 78 serious incidents (SIs) in emergency and urgent care, which met the reporting criteria set by NHS England from May 2018 to May 2019.

A breakdown of the incident types reported is shown below:

Incident type	Number of incidents	Percentage of total
Treatment delay meeting SI criteria	58	74.4%
Sub-optimal care of the deteriorating patient meeting SI criteria	7	9.0%
Medication incident meeting SI criteria	5	6.4%
Confidential information leak/information governance breach meeting SI criteria	4	5.1%
Commissioning incident meeting SI criteria	2	2.6%
Adverse media coverage or public concern about the organisation or the wider NHS	1	1.3%
Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant)	1	1.3%
Total	**78**	**100.0%**

(Source: Strategic Executive Information System (STEIS))

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. However, polices were not always updated by the responsible members of the executive team when there were changes to national guidance or as a result of learning from adverse events.

Staff had access to a range of professional guidelines, policies, and procedures to inform their practice. These were accessible via the 'Pulse' intranet page. We reviewed a number of such policies and procedures and found the majority were past their review date and some had not been updated in line with changes to national guidance or when an incident review resulted in a change in practices. Staff had access to the trust's policies and procedures via personal electronic devices which they took out in vehicles with them and via computers in the stations. Following the inspection, the trust took urgent action to address this issue and a new system had been developed, which we saw during the well-led inspection. This provided improved oversight of the policies and procedures. Individual staff members were assigned responsibility for these.

As we reported during our last inspection, staff had a number of patient treatment and care pathways to follow, including; identifying and responding to sepsis in adults and children; stroke, major trauma, and heart attack. There was a pathway for hospice and end of life care. In addition, there was formal guidance for making the arrangements for patients requiring transfer for an immediate lifesaving intervention.

Staff had JRCALC pocket-books with them and told us they referred to them in conjunction with the trust's digital pocket guide (DPG), which was accessible on their personal electronic devices. The DPG was an electronic resource for staff providing local policies and guidance as well as national safety alerts and reference cards.

The trust shared information on clinical updates and latest guidelines through electronic bulletins and the news bulletin 'Clinical Update'. We viewed the July 2019 issue and found clinical updates on subjects such as, co-ordinate my care (CMC), end of life care medication and heart failure. The bulletin also provided a case study on CMC. There was also a "bear in mind", which provide short soundbite on important key messages.

Evidence based care bundles and pathways were available for staff on their personal mobile electronic device. These included specific pathways for patients presenting with symptoms of a stroke and sepsis. Staff showed us how to access the information they required on their personal electronic device.

We reviewed a range of clinical newsletters (PULSE and Insight) and updates distributed to ambulance staff and posted on noticeboards in the mess rooms in the stations we visited. They provided updates on clinical matters, changes to clinical practice, NICE guidelines, review of any procedures, information governance and details of both internal and external training courses that were available.

The trust monitored all relevant National Institute for Health Care Excellence (NICE) guidelines to ensure staff were always kept up to up to date in practice.

The trust had appointed five senior sector clinical leads who were focused on appropriate referrals to alternative pathways.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief advice in a timely way.

As we reported during our previous inspection, staff effectively responded to and managed patient's pain. We observed staff asking patients about their level of pain at regular intervals during the patients care. Staff used a pain assessment tool and were able to record the patient's pain score on their records.

During patient handover at hospitals, we heard ambulance crew describe the patient's level of pain and the pain relief, which had been administered. Patients told us crew regularly asked them whether they were in pain and if the pain relief given was working.

We observed pain relief administered and managed appropriately. We saw staff offering pain relief orally and intravenously. Staff explained any potential side effects to patients. We also saw staff checking what patients had already administered themselves and undertook a risk assessment based on dosage taken before giving any more pain relief medicines.

For children and adults who were unable to verbally communicate, staff used the FLACC score system (Face, Legs, activities, cry and console ability) and is a measurement used to assess pain for children between the ages of two months and seven years or individuals that are unable to communicate their pain. The scale is scored in a range of 0–10 with 0 representing no pain. Where necessary staff told us, they would use pictorial representation of pained faces for patients to point towards.

Patients we spoke with told us they were provided with adequate pain relief and were asked about their allergies. We observed staff documenting and recording allergies in the patient record form.

Response times

The service monitored, and mostly met, agreed response times so that they could facilitate good outcomes for patients. They used the findings to make improvements.

Ambulance systems (AmbSYS) indicators introduced under the NHS England Ambulance Response programme (ARP):

The following measures were introduced for this trust in November 2017 to reflect the new way of working under the ARP.

Note: Although the trust did not stipulate the date, only data from November 2017 onwards is available.

Response times

Under ARP, four new categories of call were introduced with new national standards. Mean (average) and 90th centile measures were introduced to help improve performance management of response times. The 90th centile measures indicate the time within which 90% of calls were responded to.

Please note that, for category 1T, 3 and 4 calls, there are 90th centile measures but no mean response time standards.

Category 1 calls:

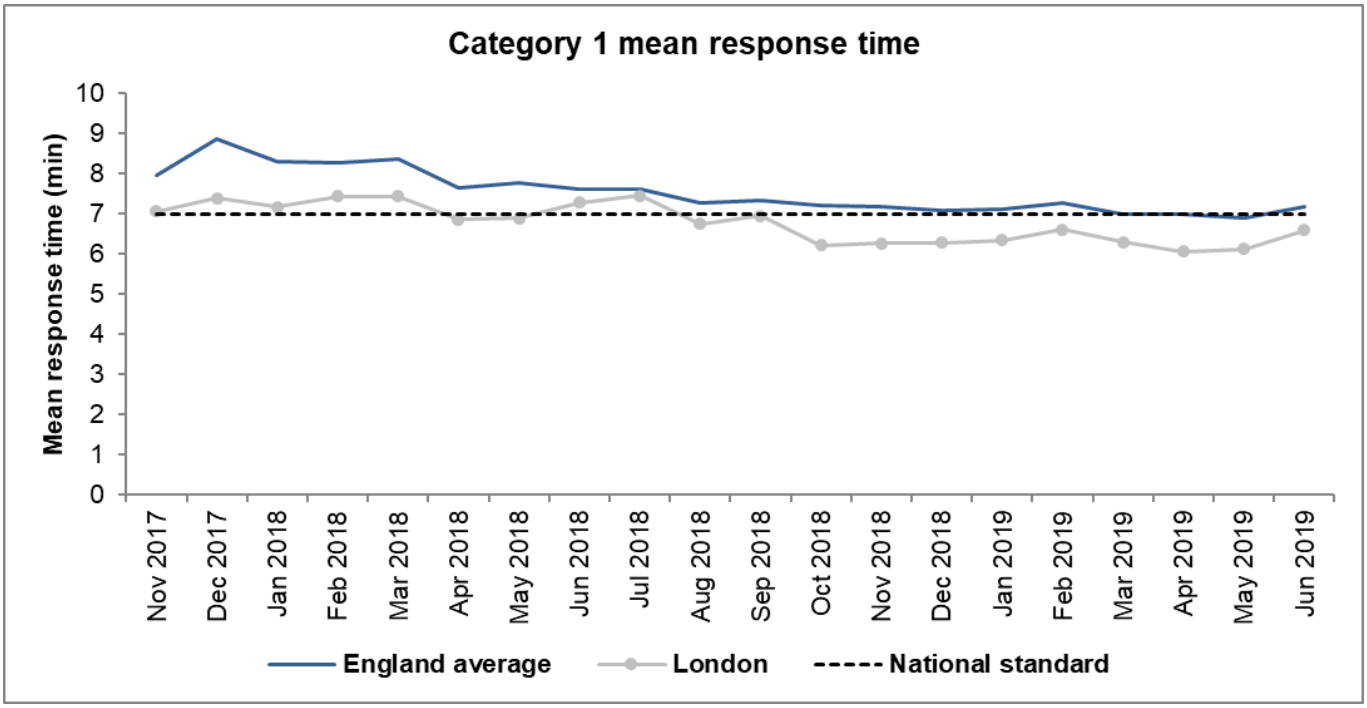
Category 1 calls are those requiring an immediate response to a life-threatening condition, such as cardiac or respiratory arrest.

The mean category 1 response time measures the average time from the time the call is received to the time the appropriate resource arrives on scene. Performance is compared against the national standard of seven minutes and against the England average, where quicker times are better.

From November 2017 to June 2019, the trust met the seven-minute national standard for 13 of the 20 months and performed consistently better than the England average.

Over the 20 months, trust performance varied between 06:04 and 07:27 minutes. In the latest month of June 2019, the trust met the national standard and performed better than the England average. In the same month, two trusts met the national standard.

Over the nine months from November 2017 to July 2018, the trust met the national standard for two months. Trust performance improved in October 2018 and has remained stable up till June 2019.

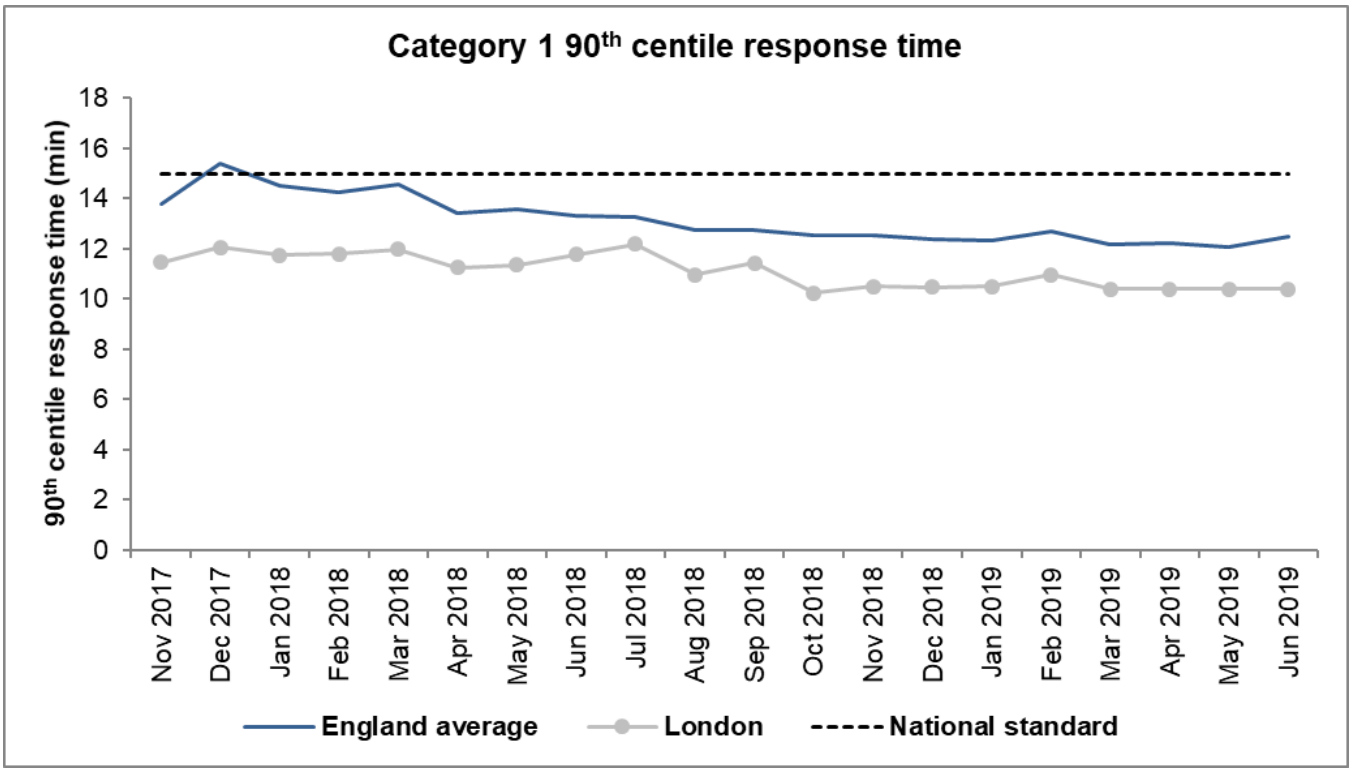


The 90th centile category 1 response time measures the time taken to reach 90% of all category 1 (life threatening) incidents. Performance is compared against the national standard of 15 minutes and against the England average, where quicker times are better.

From November 2017 to June 2019 the trust consistently met the 15-minute national standard over the 20-month period.

The trust performed consistently better than the England average over the 20-month period.

Over the 20 months, trust performance varied between 10:04 and 12:12 minutes. In June 2019, the trust met the national standard and performed better than the England average.

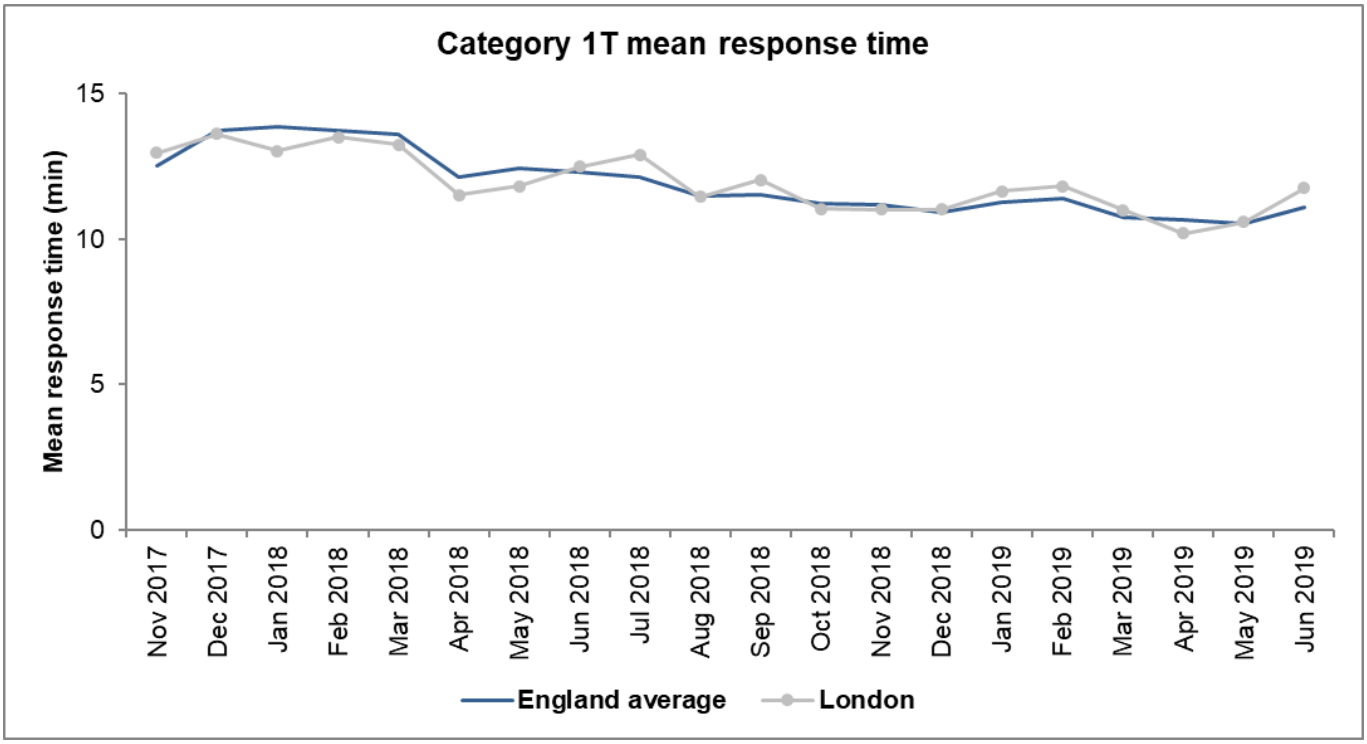


Category 1T calls:

Category 1T calls are those requiring an immediate response to a life-threatening condition, such as cardiac or respiratory arrest, which require transport. This is an additional category 1 transport standard, which is a subset of category 1, to ensure that these patients also receive early ambulance transportation.

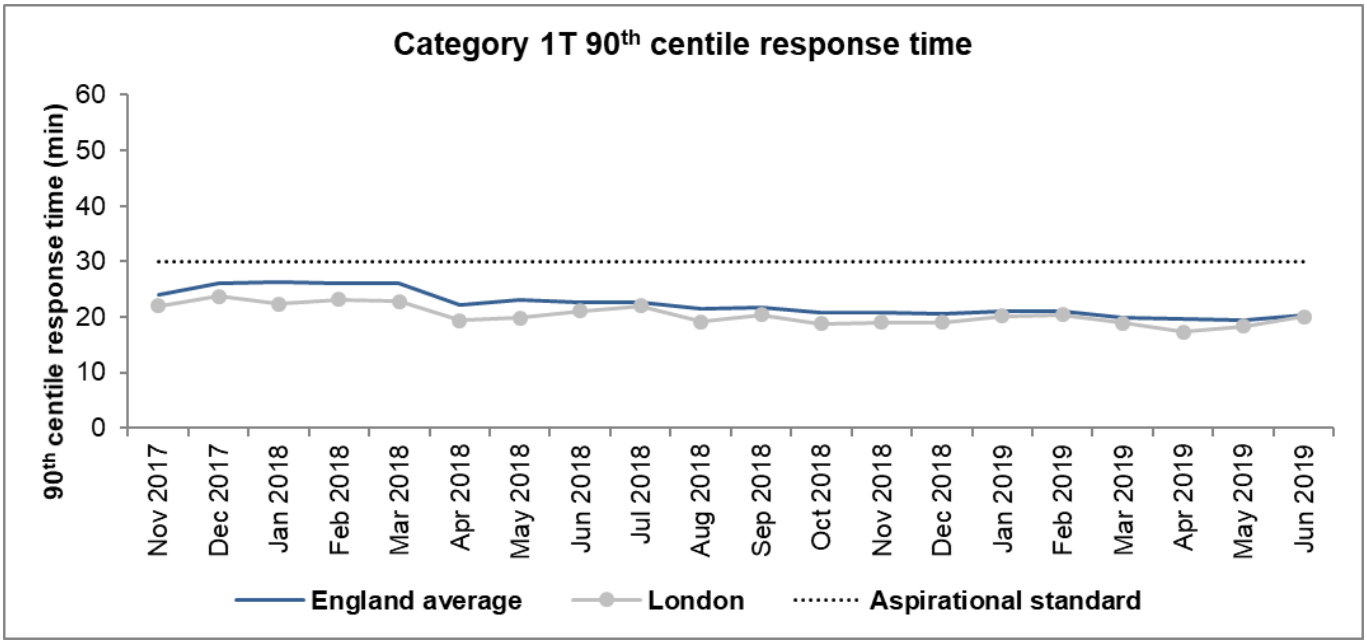
The mean category 1T response time measures the average time from the time the call is received to the time the vehicle which transported the patient arrived on scene for category 1 (life-threatening) incidents which require transport. No national standard exists for this measure. Performance is compared against the England average, where quicker times are better.

From November 2017 to June 2019 the trust performed similar to the England average.
Over the 20-month period, the trust's performance ranged from 17:18 and 23:45 minutes. The England average ranged from 10:32 to 13:54 minutes.



The 90th centile category 1T response time measures the time taken to reach 90% of all category 1T (life threatening) incidents which require transport. No national standard exists for this measure; however, trusts are encouraged to use a 30-minute aspirational target. Performance is also compared against the England average, where quicker times are better.

From November 2017 to June 2019 the trust consistently met the 30-minute aspirational standard. The trust performed better than the England average over the 20-month period.



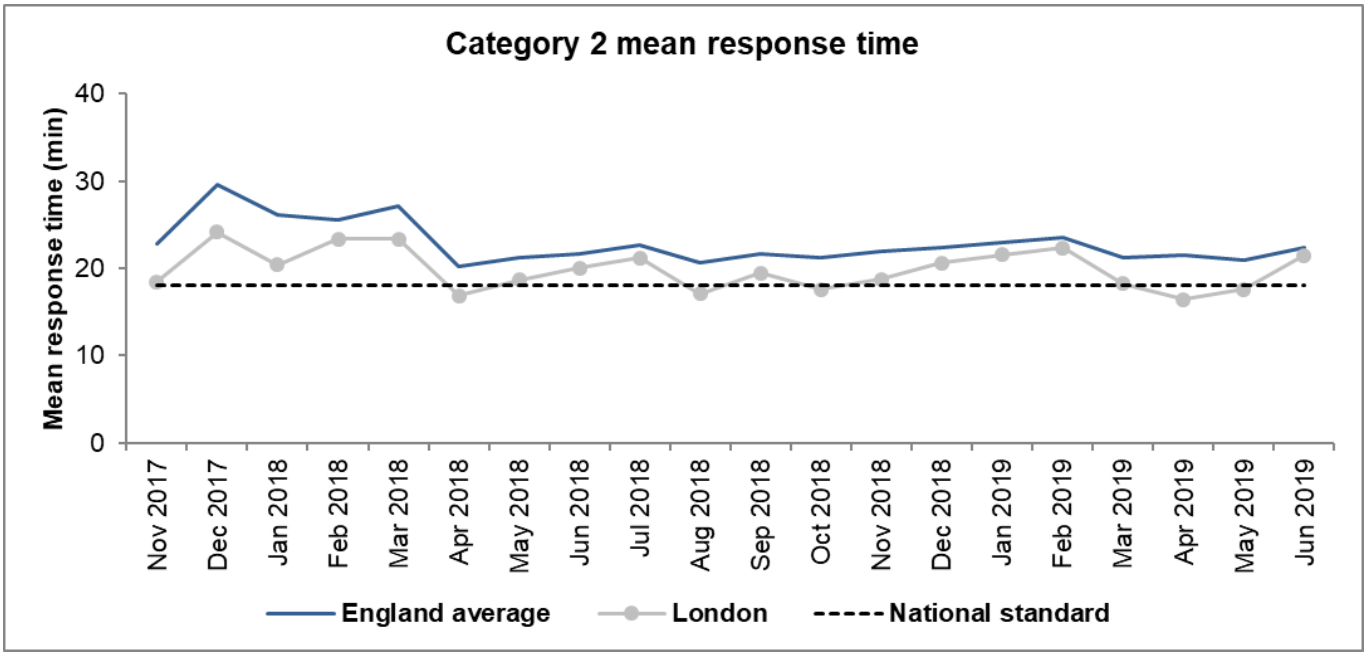
Category 2 calls:

Category 2 (emergency 999) calls relate to serious conditions, such as stroke or chest pain, which may require rapid assessment and/or urgent transport.

The mean category 2 response time measures the average time from the time the call is received to the time the appropriate resource arrives on scene. Performance is compared against the national standard of 18 minutes and against the England average, where quicker times are better.

From November 2017 to June 2019 the trust met meet the 18-minute national standard in five months and was worse than the standard in 15 of the 20 months. The trust performed consistently better than the England average over the same period.

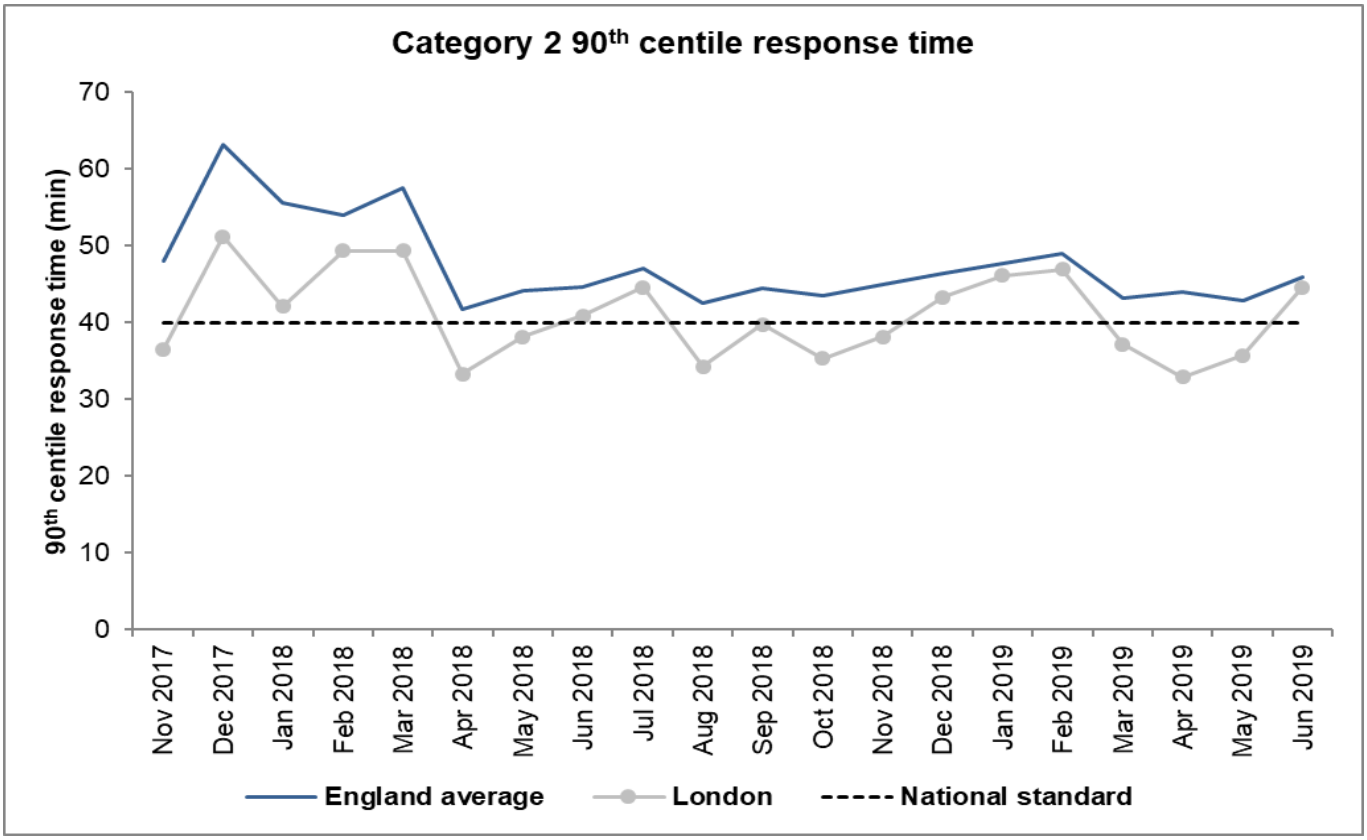
Over the 20 months, trust performance ranged from 16:26 and 24:11 minutes. The England average ranged from 20:15 to 29:41 minutes. In June 2019, the trust did not meet the national standard. However, the trust performed better than the England average.



The 90th centile category 2 response time measures the time taken to reach 90% of all category 2 (emergency) incidents. Performance is compared against the national standard of 40 minutes and against the England average, where quicker times are better.

From November 2017 to June 2018 the trust met the 40-minute national standard in ten months and was worse than the standard in the remaining ten months over the 20-month period. The trust performed consistently better than the England average throughout this period.

Over the 20 months, trust performance ranged from 32:55 and 51:11 minutes. The England average ranged from 41:42 to 63:14 minutes. In June 2019, the trust did not meet the national standard. However, the trust performed better than the England average.



Category 3 calls:

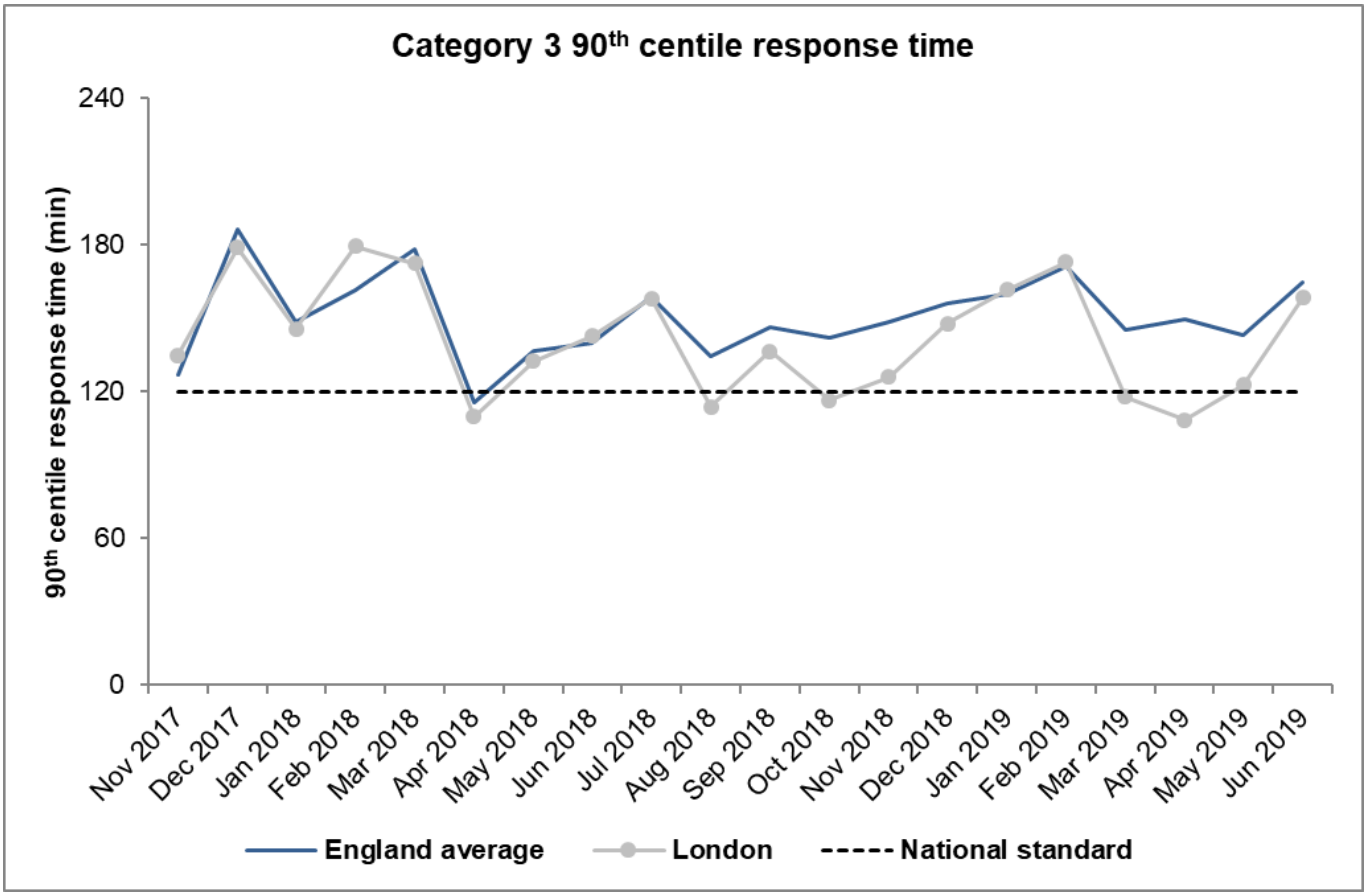
Category 3 (urgent) calls relate to urgent problems, such as late stages of labour, non-severe burns and uncomplicated diabetic issues, which require treatment and transport to an acute setting. In some instances, patients may be treated by ambulance staff in their own homes.

The 90th centile category 3 response time measures the time taken to reach 90% of all category 3 (urgent) incidents. Performance is compared against the national standard of 120 minutes and against the England average, where quicker times are better.

From November 2017 to June 2019 the trust met the two-hour national standard for five months and was worse than the standard in the remaining 15 months.

The trust performed better than the England average for 15 months from November to June 2019. In the same period, trust performance ranged from 1:48:22 to 2:59:27. The England average ranged from 1:55:52 to 3:06:35.

Over the nine-month period from November 20117 to July 2018, trust performance was mostly similar to the England average. However, for the 11 months from August to June 2019 the trust performed mostly better than the England average



Category 4 calls:

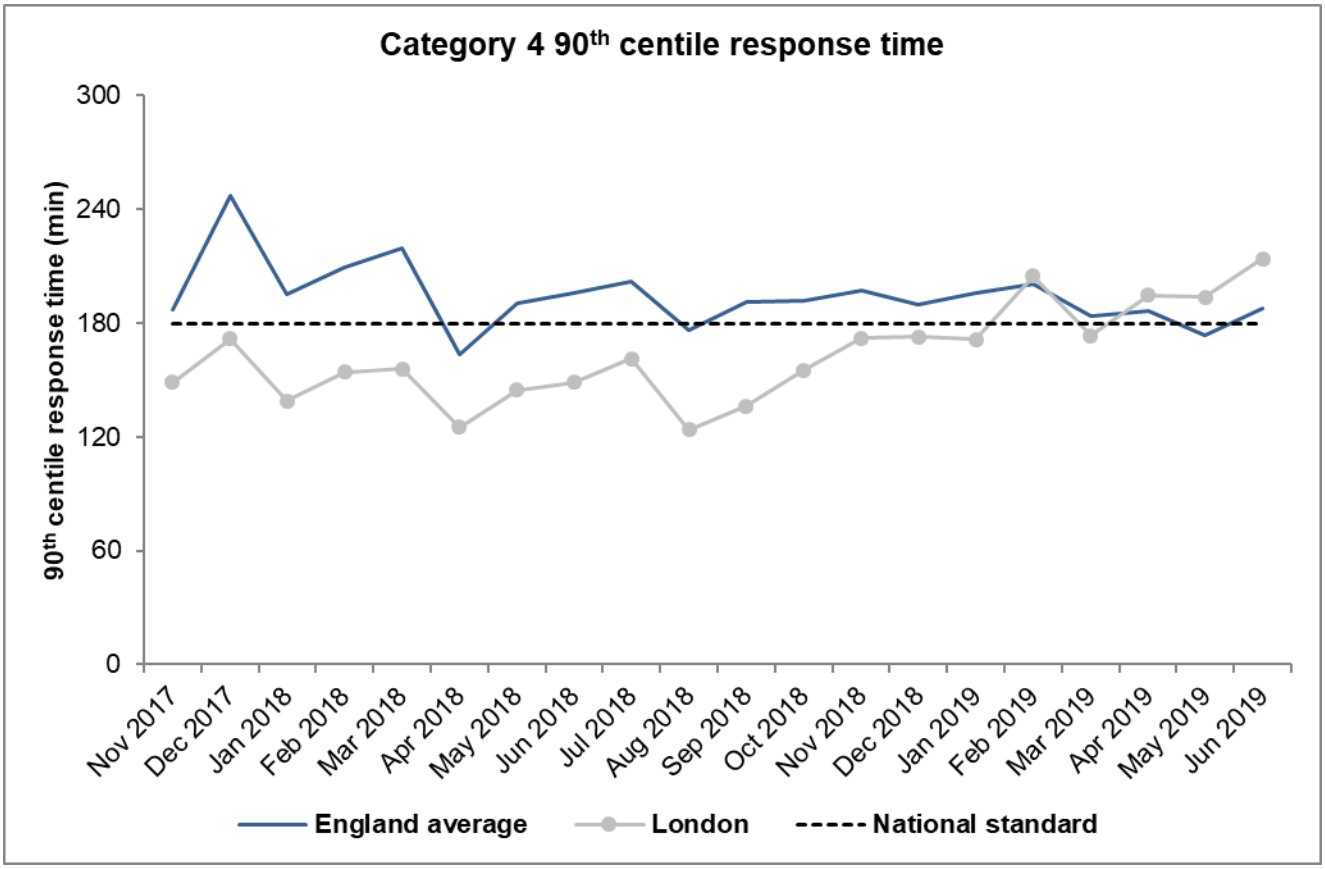
Category 4 calls relate to non-urgent problems, such as stable clinical cases for conditions such as diarrhoea and vomiting, and urinary infections, which requires transportation to a hospital ward or clinic. In some instances, patients may be given advice over the phone or referred to another service such as a GP or pharmacist.

The 90th centile category 4 response time measures the time taken to reach 90% of all category 4 (less urgent) incidents. Performance is compared against the national standard of 180 minutes and against the England average, where quicker times are better.

From November 2017 to June 2019 the trust met the three-hour national standard in 16 months and was worse than the standard in four months over the 20-month period. The trust performed better than the England average in 16 months over the same period.

Over the 15-month period from November 2017 to January 2019, trust performance was consistently better than the national standard and England average. However, from February 2019, apart from March 2019, trust performance deteriorated, and was worse than the national standard and the England average till June 2019.

Over the 20 months, trust performance ranged from 2:03:53 and 3:34:04. The England average ranged from 2:43:12 to 4:07:35.



(Source: NHS England – Ambulance Quality Indicators – Systems indicators)

Staff told us, at times, there were issues with some acute hospital emergency departments that cause some ambulance delays. All staff generally felt response targets were mostly manageable. We were told high demands at some emergency departments could affect their responses.

We looked at category 2 data in more detail and, while not always meeting the national standard for the mean or 90th centile, the trust was consistently better than the England average (albeit to varying degrees). There was deterioration in performance around mid-summer and over winter, both of which would be expected with the seasonal variations, and trend-wise this followed a similar pattern to the England average. Looking at ranking amongst the other ambulance trusts, LAS was generally around the middle. We have not identified these response times as a concern based on the data we have.

For the most part the response times looked relatively similar to the England averages and not too far off the standards, although they were poorer for categories 3 and 4.

Patient outcomes

The service monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

All staff were actively engaged in activities to monitor and improve quality and outcomes. The trust measured patient outcomes and took part in national and local audits. The service reviewed the effectiveness of care and treatment that staff provided through local and national audit along with benchmarking against other ambulance services in England.

We saw evidence that cases were clinically reviewed to determine if treatment was in line with JRCALC guidance and local protocols, if there was evidence of negative impact on the patient's condition and if there was evidence that had impacted on the patient experience.

The service used audit of individual staff competency, through clinical supervision and appraisal to monitor outcomes. Concerns or issues identified were addressed through further training and development.

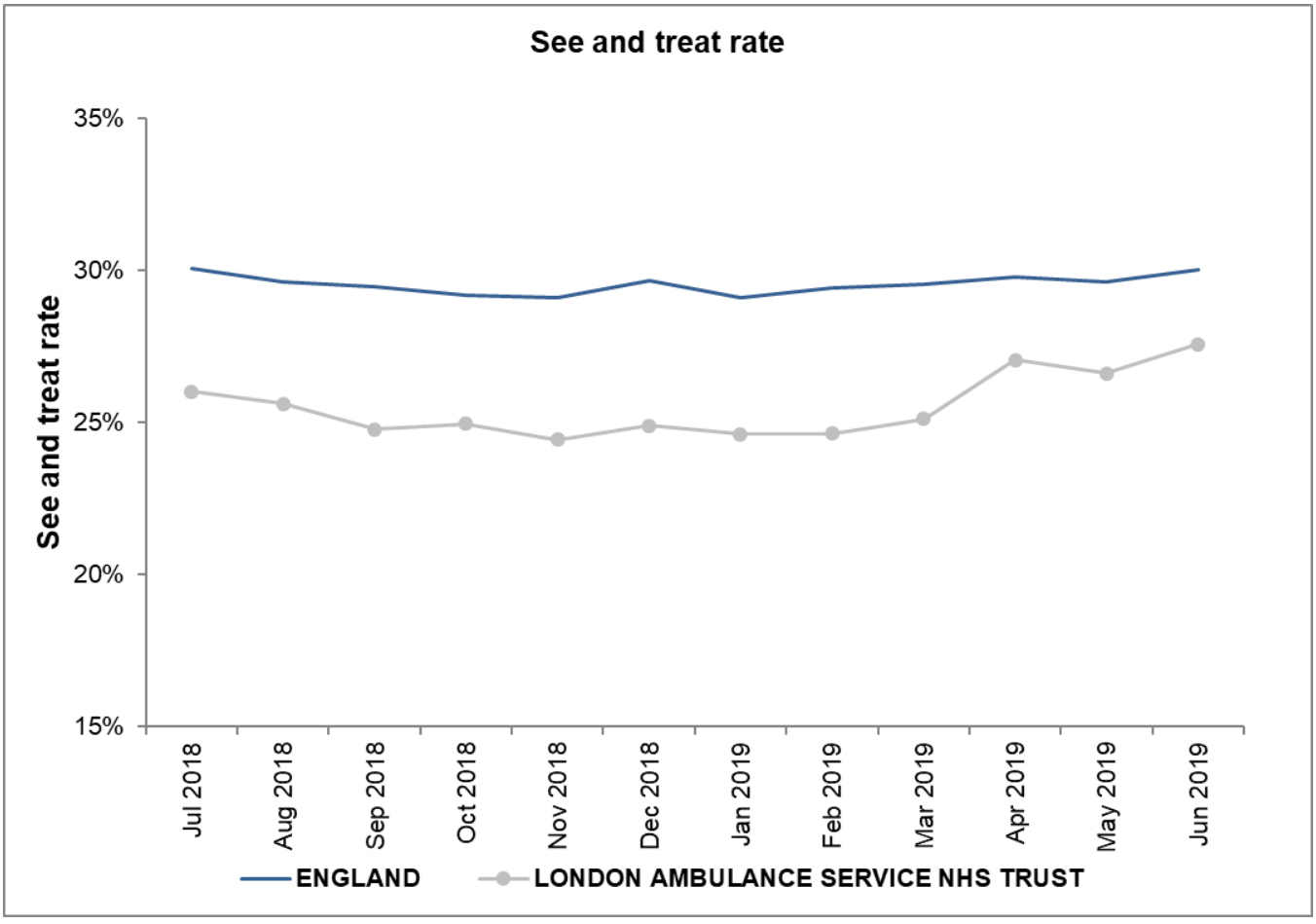
See and treat

This measure relates to all calls which resulted in an emergency response arriving at the scene and where, following assessment and/or treatment, no onward conveyance was required (but with advice and appropriate signposting or referral to alternative services).

Please note that this measure has been included for context and is not a measure of performance.

Trust percentages against the metric for the period from July 2017 to June 2018 are below.

Of the calls that receive a face-to-face response from the ambulance service, proportion managed without need for transport to Type 1 and Type 2 A&E



From July 2018 to June 2019 the trust's proportion of face-to-face calls resolved without the need for transport was consistently lower than the England average over the 12-month period.

(Source: NHS England – Ambulance Quality Indicators – Systems indicators)

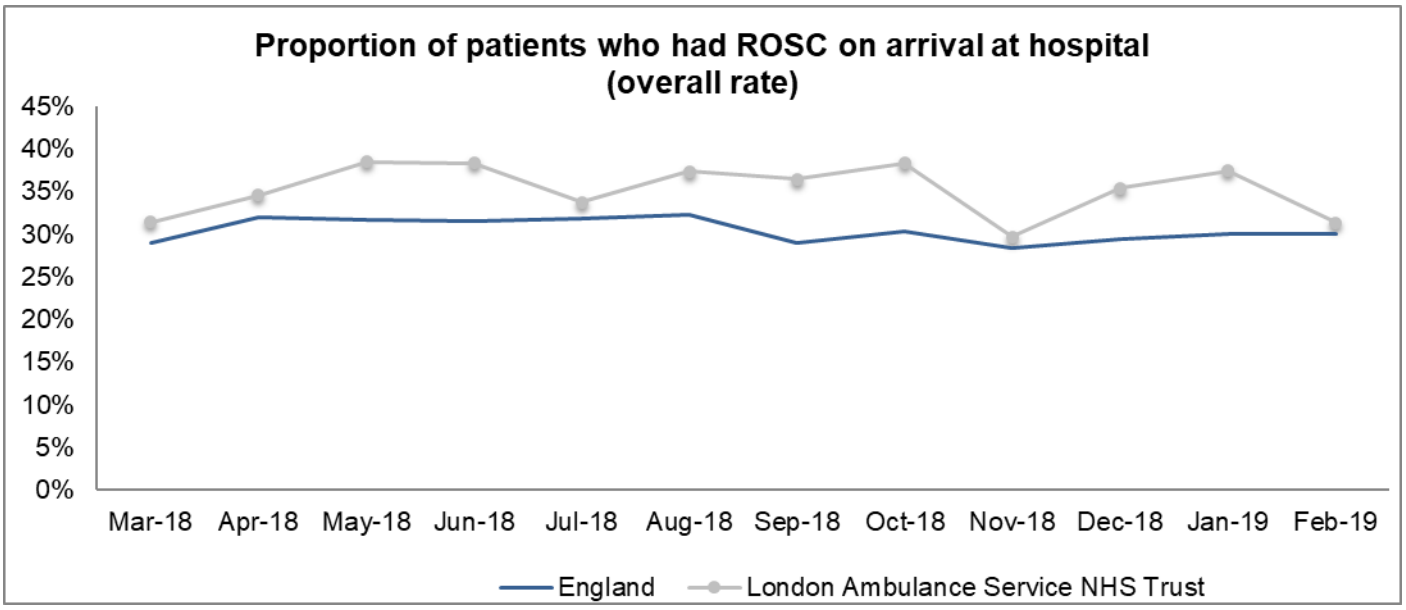
Ambulance Quality Indicator Clinical Outcomes (AmbCO)

Return of spontaneous circulation (ROSC)

Following a cardiac arrest, the return of spontaneous circulation (ROSC) (for example, signs of breathing, coughing, or movement and a palpable pulse or a measurable blood pressure) is a main objective for all out-of-hospital cardiac arrests and can be achieved through immediate and effective treatment at the scene. The return of spontaneous circulation is calculated for two patient groups.

ROSC Overall

The overall rate measures the overall effectiveness of the emergency and urgent care system in managing care for all out-of-hospital cardiac arrests.



From March 2018 to February 2019, the trust's overall proportion of patients who had return of spontaneous circulation (ROSC) was consistently better than the England average. The trust's performance ranged from 29.7% to 38.5%.

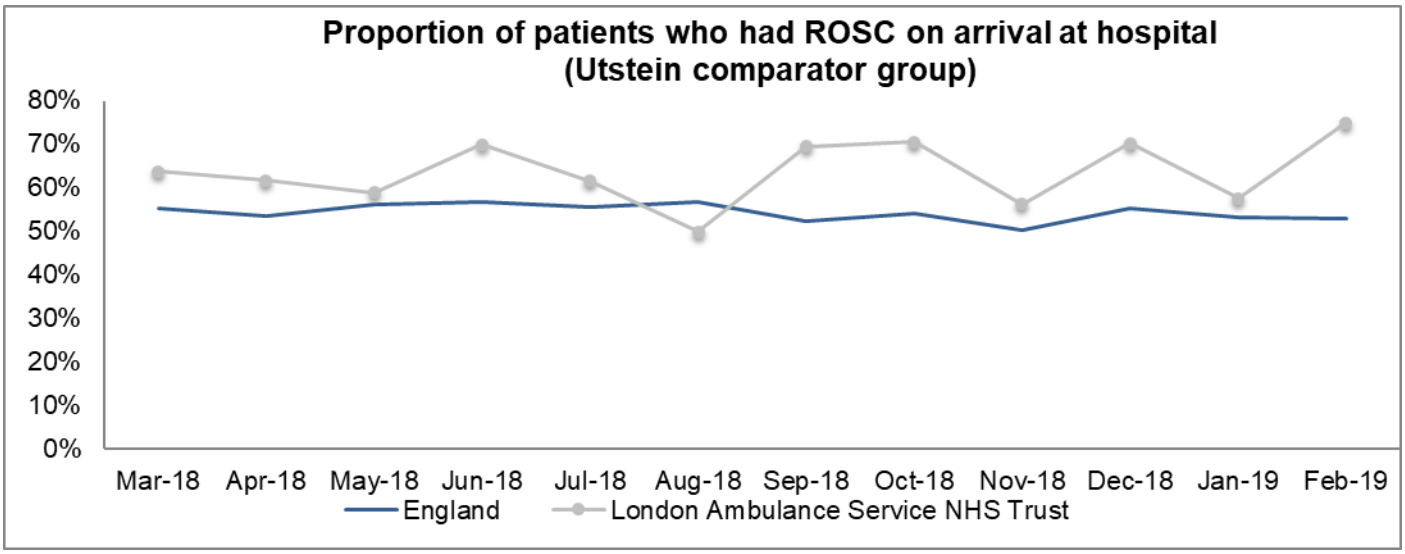
On average over the period, 35.1% of patients at the trust had return of spontaneous circulation compared to the England overall average of 30.4%.

Over to the same period in the previous year, the trust's overall average improved from 32.8% in 2017/18 to 35.1% in 2018/19.

ROSC Utstein comparator group

The rate for the 'Utstein comparator group' provides a more comparable and specific measure of the management of cardiac arrests for the subset of patients where timely and effective emergency care can particularly improve survival. For example, 999 calls where the arrest was not

witnessed, and the patient may have gone into arrest several hours before the 999 call are included in the figures for all patients but are excluded from the Utstein comparator group figure.



From March 2018 to February 2019 the trust's proportion of patients from the Utstein comparator group who had return of spontaneous circulation (ROSC) was better than the England average for 11 out of 12 months. The trust's performance ranged from 50.0% to 75.0%.

August 2018 was the only month when trust performance was worse than the England average; 50.0% compared to the England average of 56.6%.

The trust's overall average over the period was 63.5% compared to the England overall average of 54.4%.

Over the same period in the previous year, the trust overall average improved from 56.2% in 2017/18 to 63.5% in 2018/19.

Post-ROSC care bundle

Delivery of the post-ROSC care bundle aims to improve outcomes in patients with out-of-hospital cardiac arrest. This measure reflects the ability of the ambulance trust to deliver all aspects of the care-bundle. To give ambulance services time to develop new measures, 2018 data was only collected and published for April, July, and October.

This metric shows the percentage of patients with ROSC who received post-ROSC bundle, out of the number of patients who had resuscitation commenced/continued by the ambulance service following an out of hospital cardiac arrest and had ROSC on scene. Higher numbers represent better performance/ outcomes.

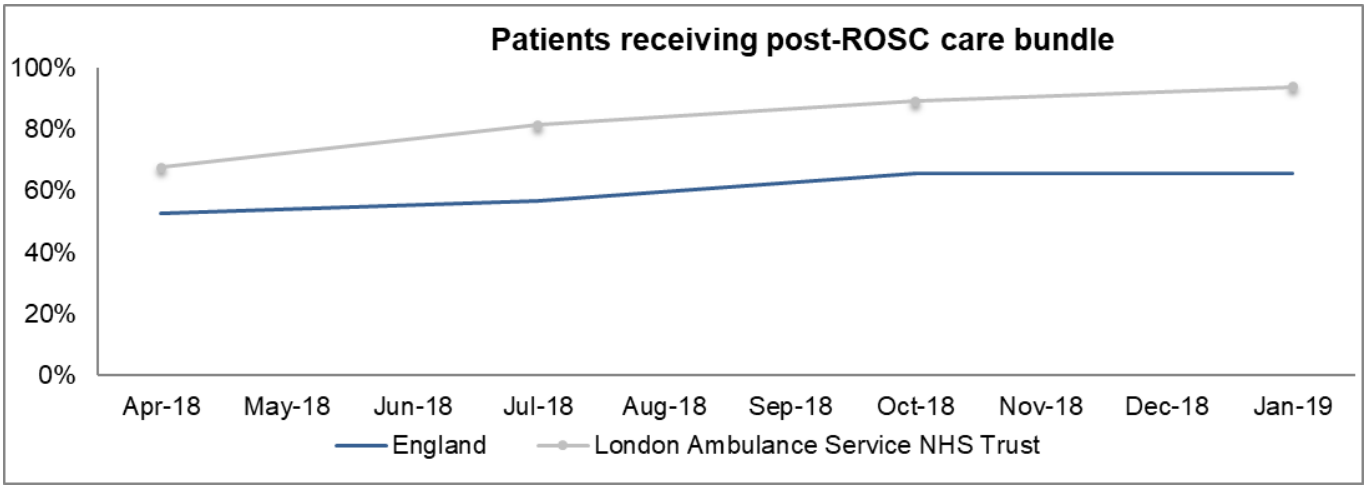
The care bundle consists of six components, all of which must be delivered unless a valid exception is present:

- 12 lead Electrocardiogram (ECG) taken post-ROSC
- Blood-glucose recorded post-ROSC

- End-tidal CO2 (ETCO2) reading / waveform recorded post-ROSC / continuously
- Oxygen administered post-ROSC / continuously
- Systolic blood-pressure reading recorded post-ROSC or, if unobtainable, presence of radial pulse documented
- Administration of 250ml bolus saline fluids post-ROSC

The metric excludes the following patient groups:

- Traumatic cardiac arrest
- Patients successfully resuscitated before the arrival of ambulance staff
- Patients aged less than 18 years.



From April 2018 to January 2019, the trust's proportion of patients who received the post-ROSC care bundle was better than the England average.
The trust's performance ranged from 67.7% to 93.9% compared to the England average which ranged from 52.6% to 65.7%.

Trust performance improved over the period from 67.7% in April 2018 to 93.9% in January 2019.

(*Source: NHS England – Ambulance Quality Indicators – Clinical outcomes)*

Outcome from acute ST-elevation myocardial infarction

Heart attack, or ST-elevation myocardial infarction (STEMI), is caused by a prolonged period of blocked blood supply. It is therefore vital that blood flow is quickly restored through clinical interventions such as primary percutaneous coronary intervention. In addition to primary treatments, however, patients with STEMI need to be managed in the correct way, including the administration of an appropriate care bundle; that is, a package of clinical interventions that are known to benefit the health outcomes of patients.

Early access to reperfusion (the restoration of blood flow) or thrombolysis and other assessment and care interventions is associated with reductions in STEMI mortality and morbidity.

The two metrics below relate to patients in the Myocardial Ischaemia National Audit Project (MINAP) admitted to hospital with an initial diagnosis of definite myocardial infarction.

Both metrics exclude patients:

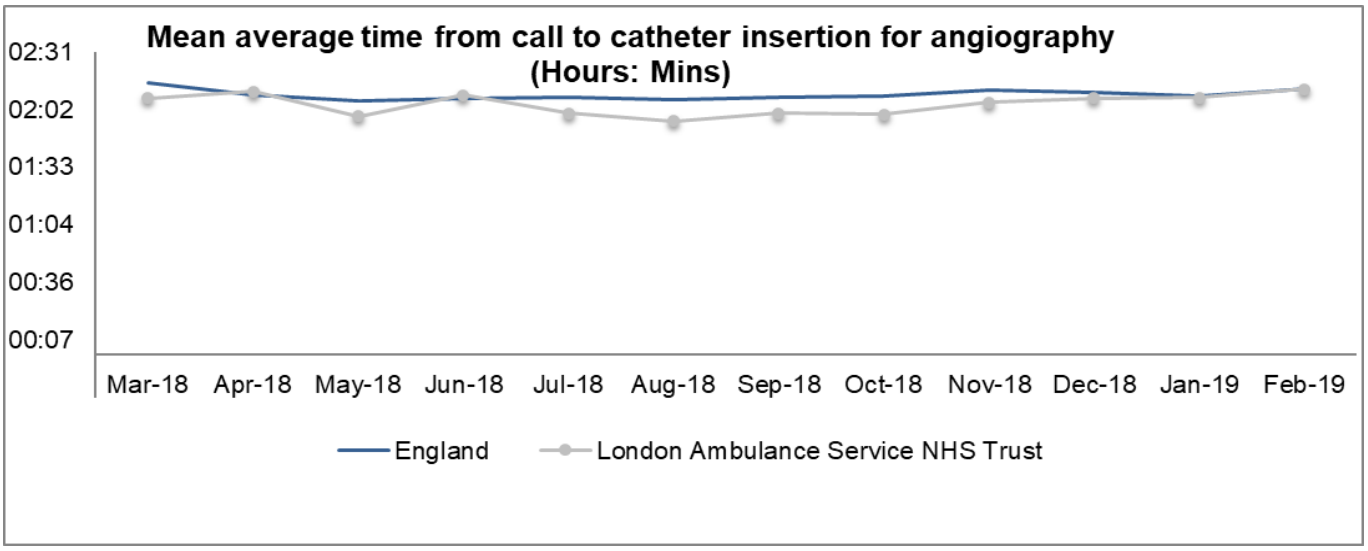
- Under 20 years of age or with age not recorded;
- Where the time is not available, or not realistic (call to angiography times less than zero or more than 1,000 minutes);
- Already in hospital, repatriated after coronary intervention, self-presenters, inter-hospital transfers, and any other or unknown admission methods;
- With cardiac arrest before arrival at hospital.

Mean time from call to catheter insertion for angiography

The first metric shows the mean time (in hours and minutes) from call for help (999 call connect time) until catheter insertion for angiography for patients admitted to hospital with an initial diagnosis of definite myocardial infarction.

Please note that catheter insertion is only performed in some hospitals. The ambulance service has no control over delays within the hospital.

Mean time from call to help until catheter insertion for angiography for patients admitted to hospital with an initial diagnosis of definite myocardial infarction

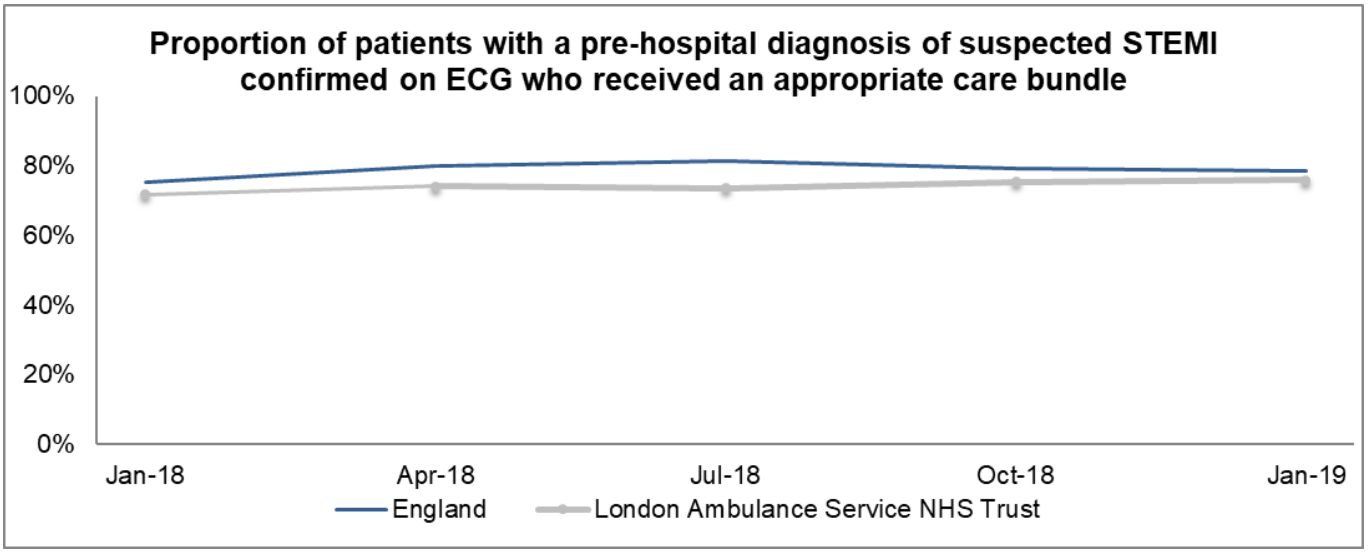


From March 2018 to February 2019, trust performance was mostly faster than the England average.

In the same period, trust performance varied between 01:56:37 and 02:12:42. compared to the England average which ranged from 02:06:29 to 02:16:02.

Proportion of patients with a pre-hospital diagnosis of suspected STEMI confirmed on electrocardiogram (ECG) who received an appropriate care bundle

The second metric shows the proportion of patients with a pre-hospital diagnosis of suspected STEMI confirmed on electrocardiogram (ECG) who received the STEMI care bundle. This is a three-monthly collection.



From January 2018 to January 2019 the trust proportion of patients with a pre-hospital diagnosis of suspected STEMI confirmed on electrocardiogram (ECG) who received an appropriate care bundle were worse than the England average. We asked the trust to provide information regarding internal review of this, the trust provided a copy of their clinical strategy 2016/17 – 2022/23 (2019

refresh) which had been presented to the trust board on the 29 September 2019. The clinical strategy indicated that the trust had reviewed the proportion of patients with a pre-hospital diagnosis of suspected STEMI confirmed by EGC and have increased the frequency of training provided to staff in ECG recognition increased, improving staff confidence and skills in ECG interpretation. The trust were also providing face to face refresher training in the identification and management of acute cardiac conditions for all operations staff which particular focus on learning from examples of good practice.

In the same period, trust performance varied between 71.9% and 76.0%. The England average varied between 75.3% and 81.3%.

(Source: NHS England – Ambulance Quality Indicators – Clinical outcomes)

Outcome from stroke

As set out in the NICE national quality standard, the health outcomes of patients can be improved by recognising the symptoms of a stroke or transient ischaemic attack (TIA), making a diagnosis quickly, and early transport of a patient to a stroke centre capable of conducting further definitive care including brain scans and thrombolysis.

The following metrics include patients that were Face Arm Speech Test (FAST)-positive and/or had a provisional diagnosis of stroke. Both patient groups are included because acute trusts can record equivalent clinical episodes under either of these two categories. Patients can be excluded if they are found to have had a Transient Ischemic Attack (TIA) and their symptoms resolve whilst with the ambulance crew.

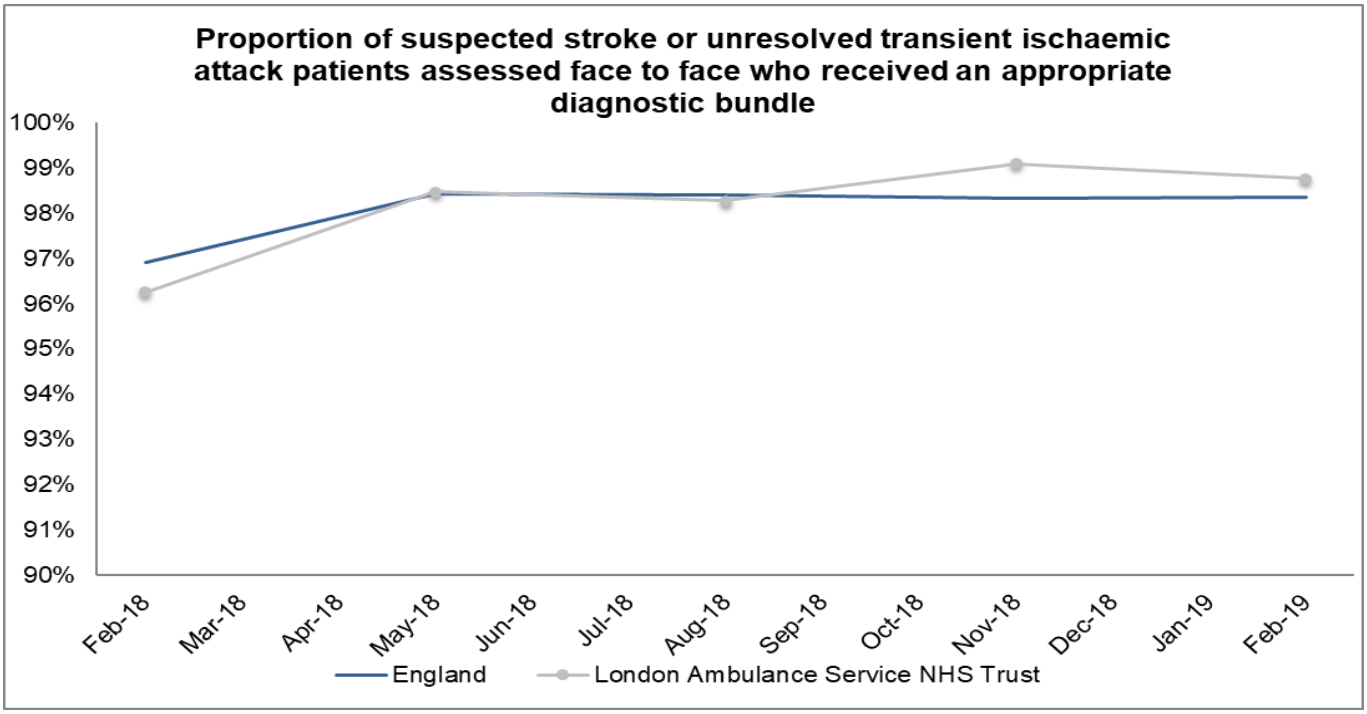
The FAST assessment helps assess whether someone has suffered a stroke:

- **F**acial weakness: can the person smile? Has their mouth or eye drooped?
- **A**rm weakness: can the person raise both arms?
- **S**peech problems: can the person speak clearly and understand what you say?
- **T**ime to call 999 for an ambulance if you spot any one of these signs.

Proportion of patients with suspected stroke or unresolved transient ischaemic attack assessed face to face who received an appropriate diagnostic bundle

This metric shows the number of patients who received the stroke diagnostics bundle out of the number of FAST positive or suspected stroke patients assessed face to face by the ambulance service. This refers to patients with a new onset/presentation of suspected stroke symptoms. It includes patients who had had a previous stroke or transient ischaemic attack (TIA) who had a new onset of symptoms.

After January 2018, stroke diagnostic bundle data items have been published every three months: February, May, August, and November. This is in order give ambulance services time to develop new measures.



From February 2018 to February 2019 the trust proportion of suspected stroke or unresolved transient ischaemic attack patients assessed face to face who received an appropriate diagnostic bundle were mostly similar to the England average.

In the same period, trust performance varied between 96.3% and 98.8%. The England average varied between 96.9% and 98.4%.

Outcome from stroke: patients that were FAST-positive and / or had a provisional diagnosis of stroke

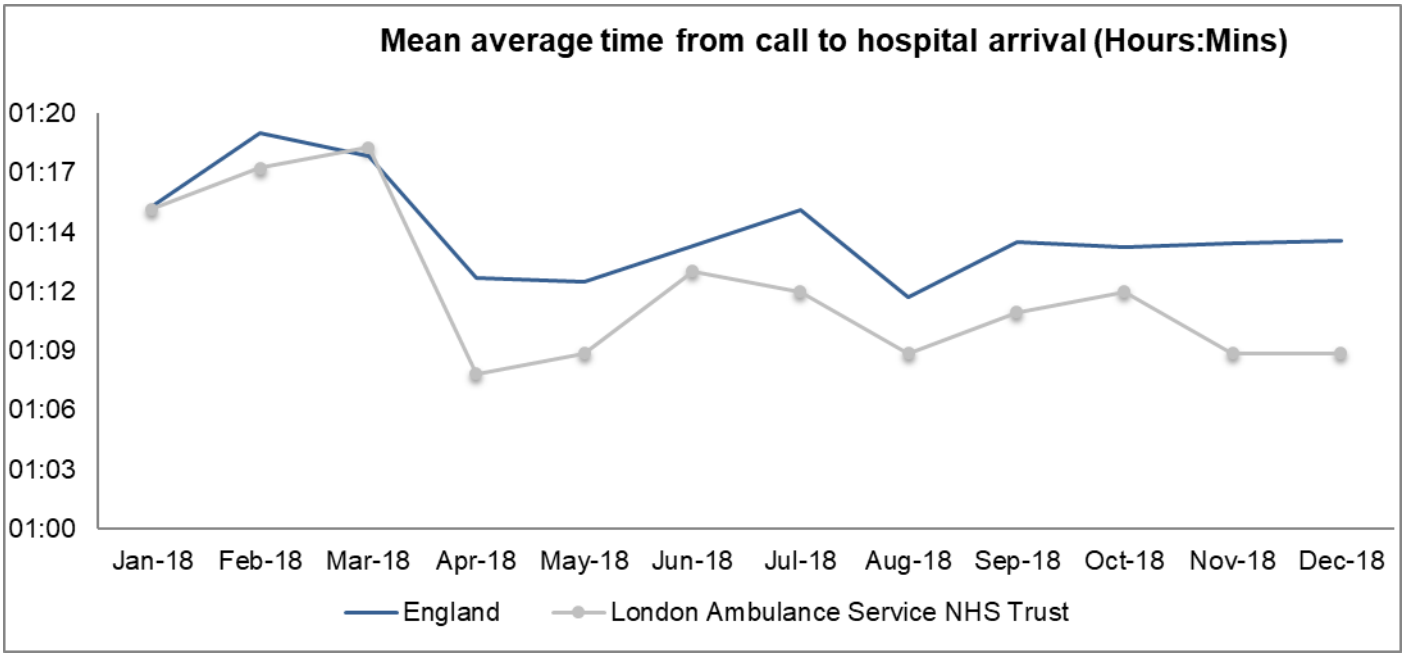
This consists of the following three metrics:

1. Call to door (number of patients either FAST positive, or with provisional diagnosis of stroke, transported by the ambulance service)
2. Door to scan (timings related to stroke patients in SSNAP who had a CT scan)
3. Door to thrombolysis (timings related to stroke patients in SSNAP who had thrombolysis)

We do not report on door to scan and door to thrombolysis measures as these are outside the care provided by the ambulance service.

The trust's results for call to door is shown in the chart below together with the England performance for comparison. The call to door time represents the time from when the call for help was connected until hospital arrival for patients that were either FAST positive or had a provisional diagnosis of stroke assessed face to face by the ambulance service. This refers to patients with a new onset/presentation of suspected stroke symptoms. It includes patients who had had a previous stroke or TIA who had a new onset of symptoms.

Call to door: time from call for help to hospital arrival for patients that were either FAST positive, or had a provisional diagnosis of stroke



From January to December 2018 the trust's mean call to door time from call for help to hospital arrival for patients that were either FAST positive or had a provisional diagnosis of stroke was consistently slower than the England average.

In the same period, trust performance varied between 01:08:00 and 01:19:00. The England average varied between 1:11:43 to 1:19:41.

(Source: NHS England – Ambulance Quality Indicators – Clinical outcomes)

Survival to discharge following cardiac arrest

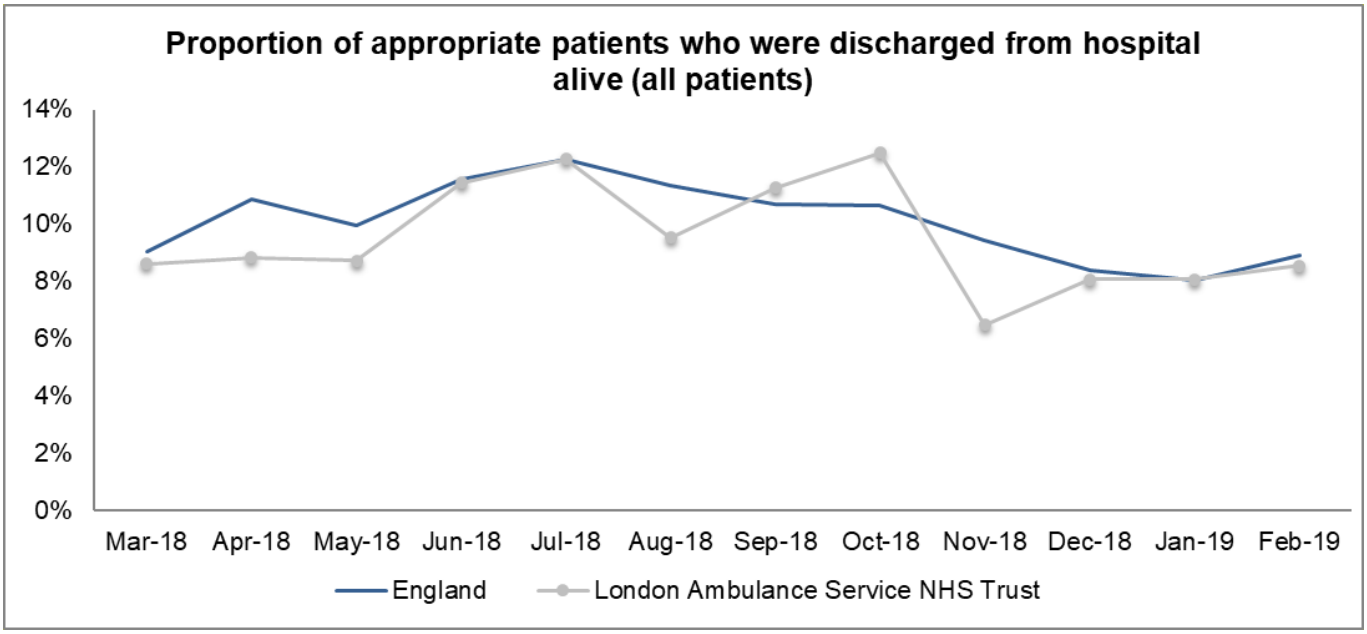
The presence of a paramedic (or doctor) significantly improves response to, and outcome from, a cardiac arrest, as the paramedic or doctor on scene can begin Advanced Life Support (ALS). By including both out of hospital and in-hospital periods of care, this measure reflects the effectiveness of the whole acute healthcare system in managing out of hospital cardiac arrest, reflecting the care delivered by both ambulance services and acute trusts.

Survival to discharge is calculated for two patient groups; the overall group, and the Utstein comparator group.

Please note that these are measures of context, not performance. As ROSC on arrival at hospital is not case-mix adjusted, a difference in performance may be due to differences in patients seen. The percentage of patients discharged alive from hospital is also dependent on hospital performance.

Proportion of appropriate patients who were discharged from hospital alive – all patients

The metric shows the number of patients discharged from hospital alive out of the number of patients who had resuscitation (Advanced or Basic Life Support) commenced or continued by ambulance service following an out-of-hospital cardiac arrest. It excludes patients for whom survival outcome is not known.

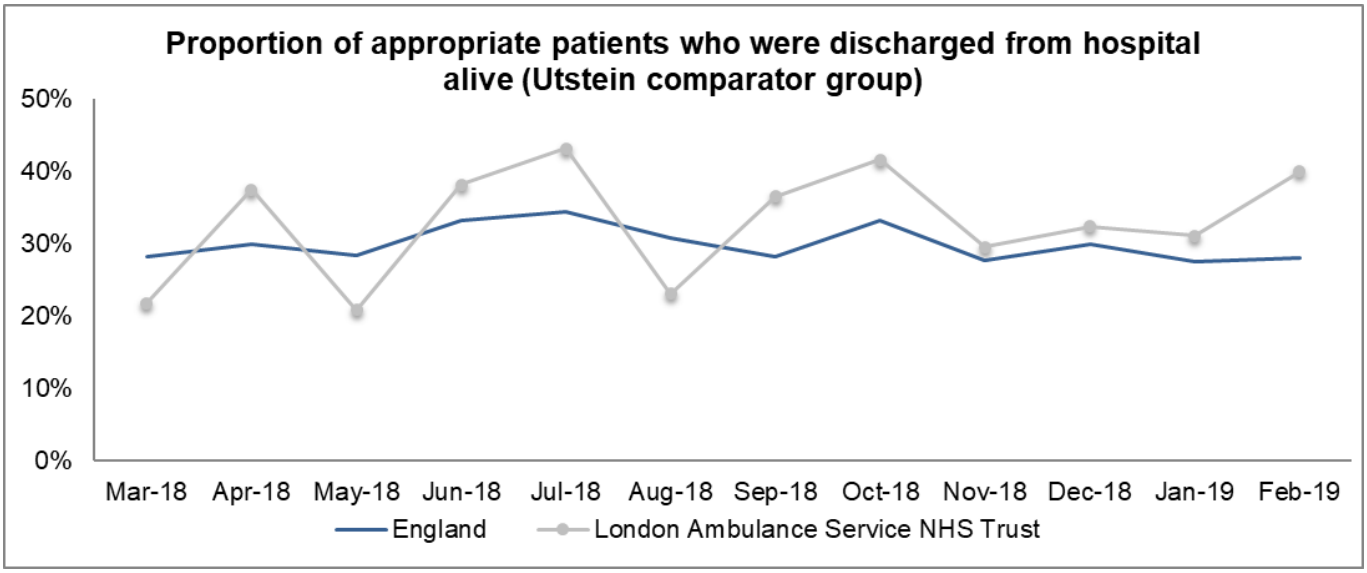


From March 2018 to February 2019 the trust's proportion of patients who had resuscitation commenced/continued by ambulance service following an out-of-hospital cardiac arrest who were discharged from hospital alive (all patients) was mostly lower than England average.
Trust performance varied between 6.5% and 12.5%.

Compared to the same period in 2017/18, trust performance deteriorated in 2018/19. The trust performed better for four and worse than the England average for eight months from March 2018 to February 2019.
In the previous year March 2017 to February 2018, the trust performed better for nine and worse than the England average for three months.

Proportion of appropriate patients who were discharged from hospital alive – Utstein comparator group

The metric shows the number of patients discharged from hospital alive out of the number of patients who had resuscitation (Advanced or Basic Life Support) commenced or continued by ambulance service following an out-of-hospital cardiac arrest of presumed cardiac origin, where the arrest was bystander witnessed and the initial rhythm was ventricular fibrillation or ventricular tachycardia. It excludes patients for whom survival outcome is not known.



From March 2018 to February 2019 the trust's proportion of patients who had resuscitation commenced/continued by ambulance service following an out-of-hospital cardiac arrest who were discharged from hospital alive (Utstein comparator group) was mostly higher than the England average. In the same period, trust performance varied between 20.8% and 43.2%.

Trust performance in March 2018 to February 2019 compared to previous year from March 2017 to February 2018 was similar. In both periods the trust performed better for nine months and worse than the England average for three months.

(Source: NHS England – Ambulance Quality Indicators – Clinical outcomes)

Competent staff

The service made sure staff were competent for their roles. Managers appraised most staff's work performance and held supervision meetings with them to provide support and development.

Paramedic staff were registered with the appropriate body. Paramedics are required to register with the Health and Care Professional Council (HCPC) and are required to re-register every two years. They are required to undertake continuous professional development (CPD) and receive clinical supervision as part of their registration.

Staff spoke positively about the induction they received. They attended a local training centre for several weeks training and corporate induction before going out on operational placements and receiving local induction. Staff were required to have a minimum requirement of skills and competency. This was achieved through statutory and mandatory training as well as additional training specific for staff working in the ambulance service.
Staff had the appropriate qualifications, skills and experience to do their job. Staff we spoke with were knowledgeable about their role.

The majority of staff we spoke with during the inspection told us they had had an appraisal in the last year, although some staff said their appraisal had been cancelled due to operational capacity reasons. We were not told if their appraisals had been rescheduled within an appropriate timeframe.

The clinical team managers aimed to provide two clinical supervision shifts per year and mentorship to all operational ambulance staff to work to ensure a high-quality patient experience and clinical outcomes. They provided clinical and operational support, mentorship and supervision which included peer to peer support. The clinical team managers we spoke with said they were frustrated as they were not always able to achieve this due to a variety of issues including understaffing of the clinical team managers and cancelations due to higher than expected demand on the service.

As we had reported during our previous inspection, emergency ambulance crew (EAC) were able at this time to undertake a paramedic science degree through the trusts in-house Academy. However, staff still told us it was difficult to gain access into the Academy and this was still a source of frustration with EACs.

Teaching events and continual professional development (CPD) were held in each sector. There was a good range of events throughout each core sector, ranging from advanced life support, mental health training, reflective sessions, maternity CPD sessions, major incident training and an urgent pathway session, clinical skills practice, training on the use of EZIOs done on mannequins and cadavers (at the morgue). CTMs organised local skills training on topics staff requested, mental health, maternity and end of life care.

We saw information about local leads for end of life care – information displayed in the mess room of one of the stations we visited.

Since our previous inspection the trust had been running a mental health joint response car in the south east London area. The car was staffed with a paramedic and a mental health nurse and operated for 12 hours daily from 11am to 11pm. the service provided us with a report of the first three months evaluation of the service. The evidence presented indicated that the conveyance rate to an emergency department was nearly two thirds less than for emergency ambulances. Patients being able to remain at home and have access to services in the community compared to being taken to an ED was 52% compared to 17%. Staff we spoke with provided very positive feedback regarding the service.

Appraisal rates

As at March 2019, 82.7% of staff within emergency and urgent care services at the trust received an appraisal compared to a trust target of higher than 85%.

The breakdown by staff group is shown below:

Staff group	March 2019				
	Eligible staff	Staff who received an appraisal	Completion rate	Trust target	Met (Yes/No)
Qualified ambulance service staff	2,810	2,360	84.0%	85%	No
Support to ambulance service staff	432	337	78.0%	85%	No
NHS infrastructure support	42	19	45.2%	85%	No
Total	**3,284**	**2,716**	**82.7%**	**85%**	**No**

(Source: Trust Provider Information Request – Appraisals)

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

As we reported following our previous inspection, we observed staff work well with external organisations. The handovers we observed at the hospitals we visited, were detailed, all information relating to the patient's condition, treatment, and care was explained to the hospital staff. Hospital staff we spoke with in the EDs across London told us they had a good working relationship with ambulance service and the information relevant to the patient assessments and treatment was always detailed and explained in full.

We observed good multidisciplinary working between the ambulance crew and police when treating a patient with mental health concerns. There was mutual understanding between the ambulance crew and police and clear lines of responsibility when dealing with the patient.

The trust had a multi-professional leadership team within the Clinical and Quality directorates. The trust was placing particular emphasis on assessment and enhanced treatment at scene and in community settings, taking patients to alternative care settings where possible while accessing established pathways of care. Since the last inspection the service had recruited three additional midwives to support the consultant midwife. The trust had a pharmacist as part of the senior team supporting medicine management.

The trust had also introduced the rotational paramedic model. This new rotational role would provide staff with opportunities for professional development, opportunities to develop expertise in treating various patient cohorts.

As we reported during our previous inspection. There was still variance in the working relationship between the emergency operations centre (EOC) and operational ambulance crew. Staff did not always appreciate the pressure each division was under. Overall, however, most ambulance crew told us they appreciated the immense pressure staff within EOC were under and told us this highlighted as a whole how busy the service was.

We observed good administration support for the local management teams at stations we visited. We saw staff at all levels including paramedics, student paramedics, technicians and managers working well together. They helped each another when needed and did so with respect and care.

During our inspection, we saw patients being transported by ambulance to the appropriate service, based on their needs. Locally agreed care pathways were embedded with other providers to ensure patients were managed in a way that would achieve the best outcomes, for example we observed the crew from the mental health joint response car attending to a patient experiencing mental ill health, the team worked with the local mental health crisis team who attended the patient at the request of the crew and then arranged for transfer of the patient directly to a ward at their local mental health hospital where a bed had been arranged.

Ambulance crews told us they found the support given to them by the member of the clinical hub valuable, however, they were not always able to access them due to the demand on the clinical hub for their expertise.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff were proactive in supporting people to live healthier lives and maintain independence. We observed crews talking to patients about how to access support for alcohol misuse and smoking cessation.

Crews could give 'see and treat' advice to patients if their condition did not need an ambulance transfer to hospital. Staff arranged referrals to other services, for example to the patient's GP. When patients were not conveyed to hospital and a refer to another service had been arranged, staff provided additional advice. For example, they advised patients to contact 111 for advice or dial 999 if their condition deteriorated or they were concerned.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff could demonstrate a good understanding of the principles and values that underpinned the legal requirements in the Mental Capacity Act 2005 and Deprivation of Liberty safeguards. For example, that a person must be assumed to have capacity unless it was established that they lack capacity.

Staff we spoke with could demonstrate a good understanding of the need to gain full consent prior to any treatment and clinical interventions. Staff told us they acted in the 'best interest' of patients who were critically unwell, unconscious and unable to verbally consent. Staff we spoke with had a good knowledge of assessing capacity. They were aware of what to do if a patient lacked capacity to consent to treatment.

Staff we spoke with were aware of the Gillick competence, which is a term, used in medical law to decide whether a child (under 16 years of age) can consent to his or her own medical treatment, without the need for parental permission or knowledge.

The trust reported that from April 2018 to March 2019 Mental Capacity Act (MCA) training was completed by 98.6% of staff in emergency and urgent care compared to the trust target of 85% There were no NHS infrastructure support staff eligible to complete this training

A breakdown by staff group is shown below:

- Qualified ambulance service staff: 99.1%
- Support to ambulance service staff: 93.5%

Deprivation of Liberty Safeguards (DoLS) training

Deprivation of Liberty Safeguards (DoLS) training was included within the MCA training.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We saw staff speaking with patients respectfully and using the patient's preferred choice of name. Staff always introduced themselves when the met the patient and before they commenced any interaction or treatment. We saw that staff were respectful, polite, and friendly.

During the inspection we saw care was delivered by staff in a compassionate way in all places that care was provided including in the ambulance, patient's homes and in the emergency department. We saw staff asking patients if they were comfortable during the journey to hospital, maintaining their dignity and keeping them warm.

Staff always maintained patients' privacy and dignity. We observed staff making a conscious effort to provide dignity and privacy to a female patient whilst performing a 12-lead electrocardiogram. Staff were sensitive and clearly explained what they were doing, and they avoided using jargon. The patient told us the staff made them "feel calm and comfortable". When patients required clothing removal, staff removed the minimum amount of clothing to undertake tests to ensure their patients were comfortable, retained their dignity and they felt safe.

We observed ambulance crew caring for patients in public places, where they maintained the patients' privacy and dignity at all times. They did this by covering patients with blankets when they were transported in wheelchairs and stretchers. We heard ambulance crew ask patients if they were warm enough and if they felt comfortable.

Staff took the time needed to engage with patients. The engagement with patients we observed was caring and staff were always calm despite how busy they were. Staff did not allow work pressures to impact upon patient care. Communication between the staff and the patients and their families was consistent, clear and effective. Staff also used appropriate humour to help with relaxing the patient.

We saw staff adjusted the way they interacted and spoke with different types of patient. We saw staff speaking with children and when doing so, they knelt down to the child's level, encouraged the child to ask questions when they were carrying out their clinical observations. Staff were able to ease a frightening experience for children which also helped to put parents at ease.

Friends and Family test performance – see and treat

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

From December 2017 to May 2019 the trust had a low response rate with eight or less responses per month. Due to the small numbers we were unable to complete any meaningful analysis.

(Source: NHS England Friends and Family Test)

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

We saw staff speak to patients and their family members with respect and compassion. They demonstrated empathy when talking to patient who were in distress. They were reassuring and explained everything they were doing and would be done to the patient. In some cases, relatives required significant and repeated reassurance, which staff provided.

We saw staff continually checked patients' wellbeing, in terms of physical pain, discomfort, and emotional wellbeing. Staff gave clear explanations to patients about the care and treatment they could provide. Patients were involved in the decision-making process regarding their own care. We heard staff check with patients to ensure they understood the treatment offered, before they asked for consent.

Staff demonstrated the importance of caring for patients' family members. We saw ambulance staff making conversation with patients and their family members during ambulance journeys and asking questions about their lives. Staff appropriately shared light-hearted stories with patients which helped put them and their families or carers at ease.

We saw staff comforting and reassuring a patient who believed they were being a 'nuisance' and became upset. Staff were patient, allowing the patient to gather personal effects in their own time.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

As we reported during our pervious inspection, staff clearly explained how and why they were undertaking an assessment of people. They provided information appropriate to people's level of understanding and allowed time for people to ask questions. Staff involved patients and those close to them in decisions about their care and treatment.

We observed staff involving patients and their family or carers in their care. Staff fully informed them of their treatment. We observed ambulance staff explaining potential treatment options where possible, to allow patients to have input into their own care and sought consent at every stage of treatment. Staff gave patients time to ask questions and answered these clearly and thoroughly.

When a patient did not require hospital treatment, staff said explained this to the patient and their family and then explained how they would refer to another care provider, for example their GP.

During the inspection, we saw staff talking to patient's family members whilst their colleague attended to the patients. This ensured joint working and allowed both the patients and their relatives to be cared for.

When staff arrived at the hospital, they maintained patient confidentiality by handing over patients in details to the emergency department staff as privately as possible.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The London Ambulance Service was the busiest ambulance trust in the UK. The trust had a year on year increase in emergency calls and incidents with an ever-growing elderly population. To meet the needs of local people, the trust worked with the 32 London Clinical Commissioning Groups (CCGs) led by one main CCG and other external stakeholders to meet service delivery requirements.

As we reported during the previous inspection, the trust had a good understanding on the different types of patient groups in terms of age, race, cultures, and specific medical conditions across the different sectors in London. Through auditing and monitoring data, they were able to anticipate service demand. Stakeholder engagement managers still worked closely with their local communities to work on initiatives to improve engagement and patient care.

We saw examples of good engagement with the hospital trusts. Emergency department staff reported good working relationships with LAS and the one of the emergency department matrons told us they worked closely with their local station manager. The ambulance service had helped improve patient safety and emergency department performance through their support of the introduction of the ‘fit to sit’ programme, ‘silver trauma’ (assessment protocol for those of 75 years of age) and frailty scoring.

As we reported during the previous, the trust used their resource escalation action plan (REAP) to monitor the increased operational activity and surge management when there were spikes in demand. The trusts computer system within EOC was able to identify what hospitals ambulances were queuing at and how long each ambulance had been waiting at emergency departments.

Technology was allowing staff to access guidance, care pathways and referral information on their personal electronic devices, which allowed them to meet the needs of their patients.

Systems used by the service enabled staff to be more responsive to local people. The ‘make ready’ service enabled the crews to respond to calls without delay. The system ensured 'downtime’ of ambulances was reduced and availability was increased.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. The service made reasonable adjustments to help patients access services.

As we reported following the last inspection, the staff still recognised and respected the need to provide individualised personal treatment and care as far as they were able. The initial assessment of patients on arrival at the scene included a full review of their status, in order to identify their clinical and psychological needs. This information enabled ambulance staff to decide on the most appropriate action, for example, whether they should be taken to a specialist unit, a local ED or remain at home with advice. Clinical expert guidance was still available via the hub if needed. During the inspection, we observed crew seek advice from the clinical hub.

As we reported following the last inspection, the trust had still employed mental health nurses to work in the clinical hub and these nurses provided guidance, advice, and support to all frontline staff. The service was also running a pilot with a mental health joint response car, which had a paramedic and a mental health nurse in south east London.

We found that as we had previously reported, staff still did not have specific knowledge regarding how to care for people with a learning disability. Once again all of the staff we spoke with were eager to have more training regarding mental health and learning disabilities, so that they could provide better assessment and care to people.

Systems ensured effective communication. The service had access to an interpreting line. Staff we spoke with knew how to access this service and said they used it often. Contact details for British Sign Language (BSL) interpreters were available and the service was used when required.

Staff involved patients in decisions about their care and treatment. When appropriate, patients were supported to manage their own health by using non-emergency services such as their GP.

All staff were trained to use bariatric specialist equipment. Staff had access additional pieces of equipment to help transfer patients to the ambulance. This included a dedicated roller chairs for taking patients safely down stairs and a specialised air-filled cushion, used to help lift patients off the floor. If staff needed additional advice or support, they would liaise with the clinical hub.

Access and flow

People could access the service when they needed it, in line with national standards, and received the right care in a timely way.

As we reported during our last inspection, LAS patients conveyed to hospital become the responsibility of the receiving unit at the point of clinical handover or 15 minutes after arrival, whichever occurs first. Where delays in patient handover from LAS staff to hospital clinicians occur, LAS staff were required to continue to care for patients until hospital staff were able to facilitate handover.

Staff told us their main issue was around prolonged delays was certain emergency departments. This caused further delays for ambulance front line staff responding to the next emergencies. This was because ambulance staff were not able to handover their patients until the hospital staff in emergency department were ready to receive them. Therefore, ambulance staff were required to provide care to patients until the emergency department had capacity to receive the patient.

Patients had access to a timely urgent service. Response times for LAS were mostly better than the England average. Staff we spoke with were fully aware of what to do when patients required specialist care. Patients were transferred straight to a specialist centre instead of the local emergency department. For example, if a patient required care at a hyper acute stroke unit or a major trauma centre.

Handover delays

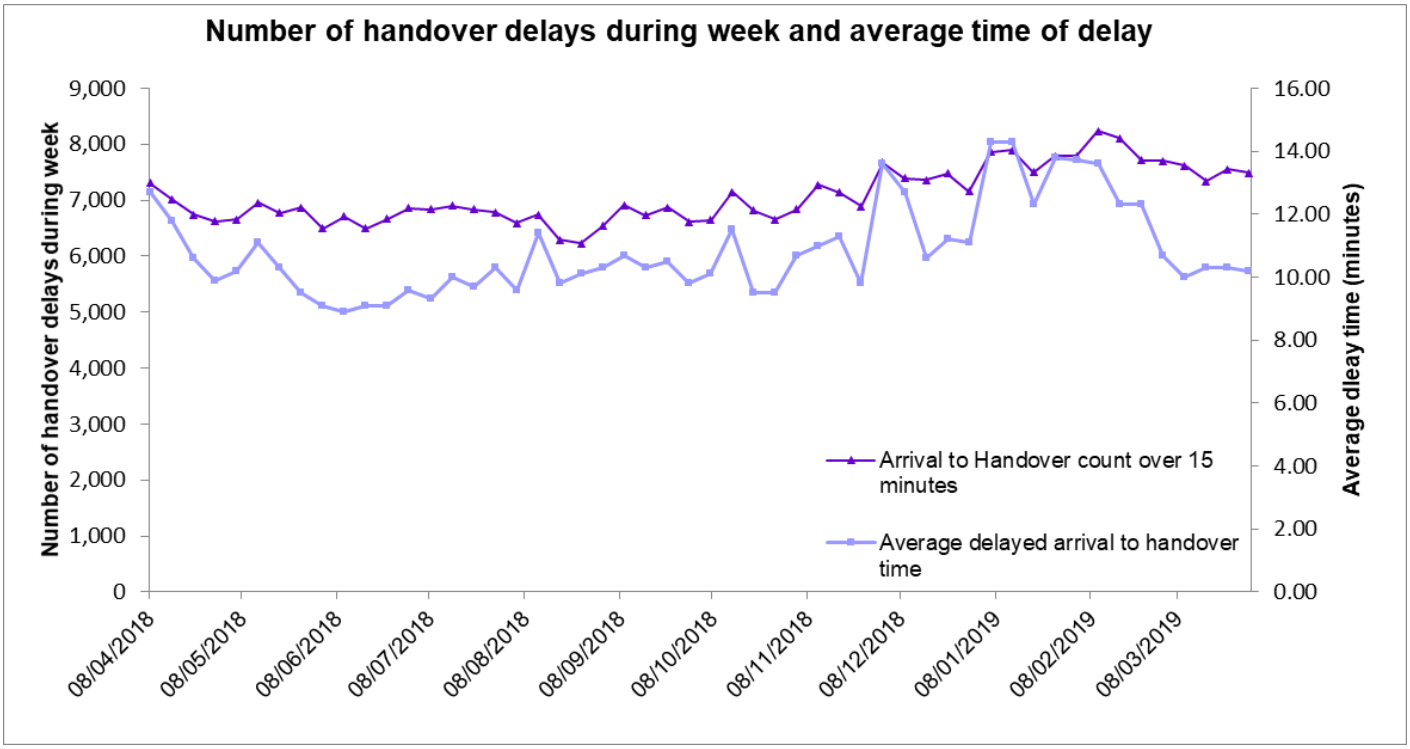
Handover start time is defined as the time of arrival of the ambulance at the Emergency Department (ED), with the end time defined as the time of handover of the patient to the care of ED staff. Best practice is considered to be 15 minutes, but handover time is a contextual measure to indicate time lost from waiting to handover patients at emergency departments and is not a measure of performance.

The trust provided weekly handover time data from week commencing 8 April 2018 to week commencing 31 March 2019. The average number of delays per week was 7,078.

From April 2018 to March 2019 the average number of handover delays followed an overall stable trend. There was however a slight decrease in the number of handover delays from April to November 2018 and a slight increase in the number of handover delays from December 2018 to March 2019.

The trust did not report any average delays over 15 minutes during the 52-week period.

The below chart shows the number of delays and the average delayed arrival to handover time each week:



(Source: Trust Provider Information Request – Handover delays)

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.

There was a very well-established complaints system in use, with a designated team responsible for the end to end process.

We reviewed three complaints which arose from patients who had used the Emergency and urgent care service. These included a complaint regarding ambulance crew attitude, the inappropriate recording of information on equipment left at a patient's home and an injury which had occurred to a patient. The process to investigate and respond to the individuals was clear and included letters of apology, along with an indication of the action taken.

On our last inspection we reported that we saw all of the ambulances we posters detailing information on how to make a complaint and staff were able to tell us how they would assist a patient if they wanted to make a complaint. On this inspection we did not see any information on ambulances about how to make a complaint, but staff we spoke with were able to tell us how they would assist a patient to make a complaint.

Complaints were received through a specific email facility. There was a system for recording complaints and actions taken in response. Themes from complaints were identified and a RAG (red, amber, green) rating was applied.

The trust had a complaints and feedback policy and procedure which was due for review in March 2018. The assistant director of operations was accountable for ensuring a full and timely response to complaints and for ensuring learning outcomes were implemented.

Summary of complaints

From April 2018 to March 2019 there were 517 complaints about emergency and urgent care (51% of total complaints received by the trust). The trust took an average of 28 days to investigate and close complaints, this was in line with their complaints policy, which says complaints should be completed within 35 working days. A breakdown of complaints by type is below:

Complaint subject	Number of complaints	Percentage of total
Conduct and behaviour	201	38.9%
Treatment	91	17.6%
Road handling	87	16.8%
Conveyance	27	5.2%
Patient injury or damage to property	21	4.1%
Delay	16	3.1%
Disputes safeguarding referral	11	2.1%
Explanation of events	11	2.1%
Information/enquiries	7	1.4%
Lost property	7	1.4%
Non-conveyance	7	1.4%
Communication	6	1.2%
Aggravating factors	5	1.0%
Clinical incident	4	0.8%
Safeguarding enquiry	4	0.8%
Dignity and privacy	3	0.6%
Location alert referral	3	0.6%
Locality alert register enquiry	2	0.4%
Other	2	0.4%
Clinical equipment	1	0.2%
Policy/ procedure	1	0.2%
Total	**517**	**100.0%**

Of all complaints received, 60.3% (312) were not upheld, 11.4% (59) were partially upheld ,6.2% (32) were upheld.

(Source: Trust Provider Information Request – Complaints)

Number of compliments made to the trust

From April 2018 to March 2019 there were 1,157 compliments collected by the trust about emergency and urgent care (73.7% of all received trust wide).

The trust stated that the key reasons and themes of compliments received were:

- the speed of response to people who were seriously ill or injured
- the caring and compassionate attitudes towards patients and their families
- the quality of medical advice and care provided.

The trust stated that they take a comprehensive approach to the analysis of situations to break down excellence to its roots to celebrate and learn from it.

(Source: Trust Provider Information Request – Compliments)

Is the service well-led?

Leadership

The majority of the leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Managers at all levels were not always visible and approachable in the service for patients and staff. They did not always support staff to develop their skills.

As we reported in our last inspection report, most staff we spoke with were positive of their local leadership. They felt well supported by their clinical team managers and local station managers. The majority of the local managers and team managers we met, were enthusiastic, passionate and well-liked by staff. They understood and managed the priorities and issues the service faced and had good working-relationships with local trusts, clinical care groups (CCGs), council and the wider community. However, staff in the fleet department did not feel supported by their leadership, they felt undervalued, they were not given opportunities for development and training and they were not consulted with regarding proposed changes to their ways of working.

At the one of the stations we visited, the location group manager (LGM) was responsible for 212 staff across five stations and reported to the assistant director of operations. They were supported by eight clinical team managers (CTMs), although there were also three vacant CTM posts. We were told this meant they sometimes had difficulty covering the 24 hours seven days per week CTM rota and had to rely on cover from other teams outside the area. This resulted in staff not always being able to access a CTM or the LGM as easily as they would wish to. At another station we visited this wasn't an issue as they had no vacancies.

Staff told us that changes to the management structure meant there were now fewer LGMs then previously when there were group station managers in place. We were also told that CTMs had been promoted to Band 7 and were now doing much more, including disciplinary procedures.

Profiles of the trust's board and organisation structure were displayed for staff and we heard that the CEO visited the stations in each sector every six month to do a 'roadshow' event to engage with staff. In addition, each regional team was assigned a specific board member. Most staff we spoke with could identify the senior leadership team. Staff told us they did not always see the chief executive officer due to shift patterns and rotas but knew their name and who they were.

Some staff said they felt very supported. Examples given included flexible working. Some staff were required to work around child care availability and said management was able to support as much as possible.

All LGMs we spoke with felt senior management were visible, approachable and all worked together well. LGMs felt they were given adequate time to perform their managerial role effectively.

As we reported following our last inspection, the majority of staff did not like the management attendance policy (MAP) and the way it was managed. During our last inspection, we reported that staff did not find the welfare call when they were off sick helpful. They felt they were being harassed. After two periods of staff sickness, staff were required to attend a MAP meeting with their line manager. Although the trust told us this was meant to be an informal discussion, staff perception was they felt they were being punished. Staff felt that at times MAP was still not managed consistently but there had been a slight improvement. It was however, still an area that caused staff great concern and high levels of stress. This had not changed at all.

The trust informed us they had launched the visible leader programme for staff at Band 8b to 8d in November 2018. It had also launched the engaging leader programme for staff at Band 7 to Band 8a in April 2019 however we were not provided with numbers of staff who had commenced the programme and no staff spoke to us about this development opportunity during the inspection.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust's vision of "Building a world-class ambulance service for a world-class city: London's primary integrator of access to urgent and emergency care – on scene, on phone and online." and values of "respectful, professional, innovate and collaborative" were displayed on numerous banners, posters and stickers around the stations we visited.

Managers were able to tell us how the trust's strategy aligned to local plans within the wider health economy. For example, one team had worked closely with their local hospital to support them to improve their emergency department service. Within the strategy the trust had included a pioneer improvement programme which had a particular emphasis on key areas of focus on to improve patient care for specific groups.

As we reported following our last inspection we found that staff demonstrated they were committed to providing good clinical care and support to patients. We observed staff whose behaviour demonstrated the values of the service. It was once again very clear that patient care was at the very foundation of the work the service did on a daily basis.

Culture

Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and within provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Most operations staff told us they felt well-supported by their managers, however, some staff told us that managers could do more to ensure staff well-being rather than focusing on performance, particularly where they have been involved in a traumatic case. Fleet staff did not feel supported by management. The fleet staff felt they were not receiving the training required to adequately look after the new fleet vehicles and they felt they had to rely on the use of agency staff to fill roles as recruitment was not being facilitated by the trust.

Operations staff felt supported by their local colleagues, but with the emergency operations centre colleagues, they felt it was an “us and them” scenario. One paramedic said they can be “rude and patronising” on calls.

The service supported staff with their wellbeing. We saw and were told about numerous examples of initiatives to improve staff well-being and support mental health awareness, including counselling services, peer support through LINC which stands for listening, informal, non-judgemental, confidential and free yoga classes.

We heard about a “wellness action plan” for staff with post traumatic stress disorder (PTSD), developed in conjunction with a mental health charity. This plan had been developed locally and rolled out to other teams across the trust. All lone workers were provided with monthly LINC sessions, run by colleagues who had received training from counsellors.

Staff told us about the freedom to speak up guardian and champions and we saw posters with contact information displayed in staff rooms and on noticeboards.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

LGMs attended a monthly quality and governance meetings as well as a monthly performance board meeting.

The service used a systematic approach to improve the quality of its services and safeguard standards of care. The service managed patient safety incidents well and responded appropriately to significant events. Monthly quality reports were used to feed quality information up to the board. We reviewed three quality reports which details information on a large variety of quality areas including patient safety, IPC, clinical ambulance quality indicators and learning from serious incidents.

There was a system of governance meetings which enabled the escalation of information upwards and cascading information from managers to front-line staff. Divisional governance meeting information was fed into the board meetings. We reviewed the papers and minutes for the August meeting of the Quality Oversight Group (QOG) which reviewed the most recent health and safety review report, the falls pilot and the report from the patient’s forum regarding the review of complaint received by the trust.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

At one of the stations we visited we were told there was 12% vacancy rate for paramedic crew but that 10 new staff were due to start by October 2019. The manager said they had escalated staffing to the risk register and trust had been quick to address this and recruit new staff. We were told that a lot of new staff had come over from overseas.

Local risks were displayed on staff noticeboards in the stations we visited. These local risk registers fed into the directorate risk register which in turn fed into the corporate risk register.

Business continuity requirements were identified, risks were mitigated against including disruptions which could affect the performance of the organisation. The trust had a business continuity plan.

Staff had access to information on governance issues which was displayed in the stations. Information included risk management, staffing, safeguarding and how to access freedom to speak up guardians.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service monitored emergency department handover delays and worked well with individual trust's governance teams to implement a shared way forward to work together.

Notice boards in the stations we visited were informative and up to date. We saw staff reading information on the notices boards and they told us they found it a useful way to keep up to date. All staff had access to computers in the stations and had been issued with a personal electronic device which they could use to access information on the directory of services and alternative pathways for patients. Notice boards separated clinical information away from general information for non-clinical staff members. LGM and CTMs were responsible for cascading information upwards and down to staff.

JRCALC ambulance guidelines and clinical practice guidelines were available in on the intranet site and on the personal electronic devices issued by the trust.

Staff had access to policies and procedures available through the internal intranet. Staff told us there was a frustration that alert bulletins, containing changes to policy, were not updated within the main policy itself. On review of the policies available to staff we noticed a significant number of polices had not been reviewed and did not contain information relating to the changes staff had received through the bulletin.

Out of date policies included: procedure for vehicle equipment use and inventory checks (review date October 2015), stroke care policy (review date October 2018) and resuscitation policy (review date January 2018). We noted a number of other policies which had not been reviewed or updated, and we brought this to the attention of the trust's executive team.

Following our inspection, the trust sent us a written response outlining actions which had been taken to ensure policies were updated. The director of corporate governance now ensured policies were up-to-date and easily accessible to staff. A review of the trusts policy register had also been undertaken in line with the trusts policy for the development and implementation of procedural documents. Responsible managers and directors had been identified for each document on the register, together with the approval route for that document.

Safety information about patients was flagged to staff by the emergency operations centre staff. This enabled ambulance crews to know in advance of any potential safety issues before they arrived on the scene. Ambulance staff could call the clinical hub for additional clinical advice and support.

Staff on the whole used their personal phones to make work related calls, for example to call to make a safeguarding referral, call a trust or GPs. Crews were issued with a radio, but all staff told

us it was too difficult to use it for making calls and the signal wasn't reliable, so they felt it was just easier to use the personal phones. Staff were not paid for their usage of their personal telephones.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Managers recognised that there was still more to do to address staff satisfaction and well-being. The service had introduced the role of "staff survey champions" to ensure staff were engaged in finding solutions to areas of concern identified in the staff survey. We heard that staff survey champions attended monthly quality and governance meetings to escalate issues to the regional quality lead and feedback staff.

We saw a "we said, we did" board with examples of where action had been taken in response to staff feedback. Including, additional training, information about manager's on-call rota, staff recognition. There was a strong focus on staff-led initiatives, for example front-line staff were involved in the development of the wellness action plan. In one of the stations we visited they had set up a local 'improvement forum' to further engage staff in improving services.

We were told that a lot of new staff had come over from overseas and managers recognised they did not always have friends and family locally, in response they had established social groups and mentor support to ensure they had a support network.

We saw examples of good engagement with local trusts, CCGs and local authorities. One GSM told us about the meetings they held with the local CCG and local authority about various issues that impacted on service delivery including alternative care pathways, mental health services, access to services at a local urgent care centre and issues such as speed bumps and other accessibility issues.

At one station we visited we heard about the work the service was doing with the local community to address knife crime, they had invited local youth groups to attend an upcoming open day at the station and to engage with staff and contribute to the design of their new "wellness garden".

The trust had allowed staff to use a vehicle to take a former member of staff with terminal cancer out to the seaside with his family.

Emergency operations centre staff attended 'ride-outs' on calls with paramedics to gain awareness of their role.

The main communication methods with staff were through the intranet site, the Insight and Clinical Update newsletters and staff notice boards in the individual stations. We reviewed the notice boards in the stations we visited and found all the information on display was relevant and in date. There was information about union representative available too.

The trust had a patient forum, which was made up of patients or relatives of patients of the service who meet regularity to discuss engagement and support the trust.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service had been piloting a mental health joint response car in south east London. The car was staffed with a paramedic and a mental health nurse and operated for 12 hours daily from 11am to 11pm. the service provided us with a report of the first three months evaluation of the service. The evidence presented indicated that the conveyance rate to an emergency department was nearly two thirds less than for emergency ambulances. Patients being able to remain at home and have access to services in the community compared to being taken to an ED was 52% compared to 17%

The trust had been running a falls pioneer service in north west London, which demonstrated significant improvement in conveyance of patients to the ED but was poorly utilised by staff.

The trust had commenced a pilot at an ambulance station in north London which allowed access to information by using the NHS Identity authentication service. Advanced paramedic practitioners worked with NHS Digital providing requirements for the new summary care record additional mobile application.

London Ambulance Service NHS Trust

Report to:	**Trust Board**			
Date of meeting:	28 January 2020			
Report title:	Annual EPRR Assurance Assessment			
Agenda item:	14			
Report Author(s):	Christopher Benson, Business Support Manager to the COO			
Presented by:	Khadir Meer, Chief Operating Officer			
History:	N/A			
Status:	☒	**Assurance**	☐	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

This paper informs the Trust Board of the outcome of the annual Emergency Preparedness Response and Resilience (EPRR) assurance review undertaken in collaboration with NHS England (London) and the National Ambulance Resilience Unit (NARU). The paper contains the following information:

- A background summary
- The final assurance level achieved
- An explanation of the core standards, which were rated fully compliant by NHS England (London)
- A copy of the action plan which has been developed for NHS England (London) to address the interoperable capability standards rated as partially compliant.
- The next steps in the process.

Recommendation(s):

The Board is asked to note the content of this report.

Links to Board Assurance Framework (BAF) and key risks:

N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☐
Performance	☐
Financial	☐
Workforce	☐
Governance and Well-led	☐
Reputation	☐
Other	☐

This paper supports the achievement of the following Business Plan Workstreams:

Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☐
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

Annual Emergency Preparedness, Resilience and Response (EPRR) Assurance Assessment

1. The Trust Board was briefed at its meeting on 29 January 2019 about the 2019/20 Emergency Preparedness, Resilience and Response (EPRR) assurance process. This is the process which NHS England (London) uses in order to gain assurance that the Trust is prepared to respond to an emergency and has the resilience in place to continue to provide safe standards of patient care during a major incident or business continuity event.

2. The Trust submitted its annual self-assessment to NHS England (London) before the deadline of 3 September 2019. The self-assessment tool was spread across three worksheets and covered 247 standards in total:

    - EPRR core standards: 49 core standards
    - Interoperable capabilities: 163 standards
        - Hazardous Area Response Team (HART) – 33 core standards
        - Marauding Terrorist Firearms Attack (MTFA) – 28 core standards
        - Chemical, Biological, Radiological and Nuclear (CBRN) – 32 core standards
        - Mass Casualties – 11 core standards
        - Command and Control – 36 core standards
        - Joint Emergency Services Interoperable Principles (JESIP) – 23 core standards
    - An additional set of questions on severe weather response, long term adaptation planning and ambulance resilience were the 'deep dive' topics for this year (35 standards). These 'deep dive' topics are not included in the Trust's overall compliance rating.

3. The self-assessment required the Trust to RAG-rate its level of compliance against each of the 247 standards. At the same time, a number of key documents and plans were submitted to NHS England (London) as supporting evidence.

4. In terms of the outcome, there are four compliance levels which Trusts can be assessed against. These are as follows:

Compliance levels	Criteria to achieve this level of compliance
Fully compliant	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation is less than 76% compliant with the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.

Annual EPRR Review Outcome

5. An assurance meeting was held with NHS England (London) on 16 October 2019 to review the self-assessment and to agree the actions which are required to address any

deficiencies. The Chief Operating Officer (who is also the Trust's Accountable Emergency Officer) was in attendance at this meeting together with the senior EPRR leads. The National Ambulance Resilience Unit (NARU) were asked to attend the meeting by NHS England (London) so that they could assess the Trust's interoperable capability standards.

6. The Trust's compliance rating for the core EPRR standards is rated as **FULLY** compliant, which means that all 49 standards have been met.

7. The compliance rating for interoperable capabilities is rated as **SUBSTANTIALLY** compliant, due to the 14 amber ratings in this area.

8. A Trust's overall level of compliance is based on the total percentage of amber and red results agreed at the review, combining core standards and interoperable capabilities. NHS England (London) formally confirmed in November 2019 that the Trust had 14 amber ratings and is therefore assessed as **SUBSTANTIALLY** compliant for EPRR under this year's process.

9. The amber ratings relate to the following issues:

    - The Trust is required to ensure contractual staffing levels for MTFA and HART staff are met.
    - The Trust is required to ensure staff have access to FFP3 masks.
    - The Trust is required to develop and embed the new standards for command and control; introducing robust governance and auditing of commander competencies, training, recruitment, and those of necessary support functions.

10. NHS England (London)'s report stated that "*The general position of the Trust has improved since the 2018 assurance process. LAS has moved from being substantially compliant to achieving full compliance across the main EPRR core standards. It is recognised that further work is required in relation to the interoperability standards and the Ambulance Resilience Standards."*

11. The full NHS England (London) and NARU reports are available to Board members on request, however, they are not appended to this briefing paper due to the confidential nature of the content.

Next Steps

12. An action plan has been developed and will be agreed with NHS England (London) to address the standards which were rated as amber as well as the four actions identified by NARU. A copy of the action plan is attached at Appendix 1 for the Board's information.

13. Regular meetings will be scheduled between NHS England (London)'s EPRR team and the Trust over the coming months to monitor and review progress against the action plan.

14. On-going monitoring and progress against the action plan will be managed by the Operational Compliance and Standards department in close partnership with the Resilience and Specialist Assets department. The action plan will be reviewed at the bi-monthly Emergency Preparedness and Response Strategic Group. Assurance will follow upwards to both the Executive Committee and the Audit Committee.

15. The Trust Board will receive an update in six months so that the Board can assure itself that adequate resources are being made available to enable the Trust to meet the requirements of these core standards.

16. The LAS EPRR annual assurance outcomes which have been reported in this paper will be shared externally with each Area Local Health Resilience Partnership (LHRP), with the formal reporting being undertaken at the next Regional Local Health Resilience Partnership meeting.

Khadir Meer
Chief Operating Officer

Appendix 1: Annual EPRR Assurance Assessment 2019-20 Action Plan

London Ambulance Service NHS Trust

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NHSE and NARU Action Plan

ID	Deliverable	Owner	Due date	Priority	Status	Progress Updates
1	Maintain 6 operational HART staff on duty per team at all times	Head of CBRN/HART	31/07/2020	High	In progress	The HART SOP and easement has been written and is in the process of being embedded. The HART pool paper is currently being signed off.
2	Maintain 10 competent MTFA staff on duty at all times	Head of Resilience & Special Operations	30/04/2020	High	In progress	Additional staff will be in post in February 2020 from the November 2019 recruitment round.
3	Frontline staff must have access to FFP3 mask protection	Director of Strategic Assets & Property	30/04/2020	High	In progress	Sufficient numbers of FFP3 masks have been purchased and all frontline staff will have been tested for mask size by April 2020.
4	Develop and embed appropriate recruitment and selection criteria for roles with command responsibilities.	Assistant Director of Operations (Resilience)	30/04/2020	High	In progress	A process has been tested on the Incident and Delivery Managers, with full roll out expected by April 2020.
5	Jobs with command functions must have them written into their contracts of employment.	People & Culture Business Partner	30/04/2020	High	In progress	Requirements are detailed in the job descriptions for these roles. Work is being undertaken to action this and undertake a restrospective review of other approptiate staff to ensure compliance.
6	Commanders must demonstrate competence against the National Occupational Standards and Schedule 2 of the NHS Standards for Ambulance Service Command and Control, and maintain CPD evidence.	Assistant Director of Operations (Resilience)	30/04/2020	High	In progress	A CPD workbook and electronic logging system are being developed to ensure compliance.
7	All Commanders must refresh their skills and competence as a 'player' in a training exercise every 18 months.	Head of Workforce Analytcis	30/04/2020	High	In progress	Attendance will be captured in ESR and will be reportable via this system.
8	There must be a process for non-compliant commanders to be suspended from command duties.	Assistant Director of Operations (Resilience)	30/04/2020	High	Complete	Trust policy HR031 (Competency and Capacity) states the suspension criteria for staff that do not meet their job requirements.
9	Command support roles, such as NILOs, Tactical Advisors and loggists must maintain CPD and demonstrate competence in their role.	Assistant Director of Operations (Resilience)	30/09/2020	High	In progress	The CPD workbooks and electronic logging systems are under development.
10	Those undertaking Medical Advisor and Forward Doctor roles must participate as a 'player' in exercise every 12 months.	Head of Workforce Analytcis	30/04/2020	High	In progress	This will be captured in ESR and will be reportable via this system.

London Ambulance Service NHS Trust

Report to:	**Trust Board**			
Date of meeting:	28 January 2020			
Report title:	Report of the Trust Secretary			
Agenda item:	15			
Report Author(s):	Philippa Harding, Director of Corporate Governance			
Presented by:	Philippa Harding, Director of Corporate Governance			
History:	N/A			
Status:	☒	**Assurance**	☒	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

This report provides the Board with information about the following:

a) Use of the Trust Seal

b) Policies for approval by the Trust Board

c) Terms of Reference for approval by the Trust Board

d) Register of Interests

Recommendation(s):

The Board is asked to note the information provided in this report and approve the policies and Terms of Reference attached to it.

This report relates to the following Board Assurance Framework (BAF) or other risk:

N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☒
Financial	☒
Workforce	☒
Governance and Well-led	☒
Reputation	☒
Other	☒

This paper supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

Report of the Trust Secretary

Introduction

1. This report provides the Board with information about the following:

    e) Use of the Trust Seal

    f) Policies for approval by the Trust Board

    g) Terms of Reference for approval by the Trust Board

    h) Register of Interests

Use of the Trust Seal

2. There have been three one entries into the Register of Sealing since the last Board meeting. These entries relate to:

    a. Ground Floor, Maritime House, Linton Road, Barking Essex IG11 8HG, between London Ambulance Service NHS Trust and Dooba Investments III Ltd (lease).
    b. First Floor, Maritime House, Linton Road, Barking Essex IG11 8HG, between London Ambulance Service NHS Trust and Dooba Investments III Ltd (lease).
    c. Third Floor, 32 Southwark Bridge Road, London SE1 9EU, between London Ambulance Service NHS Trust and Zurich Assurance Ltd (lease)

3. Board Members may inspect the register after this meeting should they so wish.

Trust Board Policies

Business Continuity Management Policy

4. The Trust's Business Continuity Management Policy was due to be reviewed in November 2019. It has been reviewed in line with the Trust's Policy for the Development and Implementation of Procedural Documents and is being presented to the Trust Board for approval. The policy is attached at Annex A to this report.

Anti-Fraud, Bribery and Corruption Policy

5. The Trust's Anti-Fraud, Bribery and Corruption Policy was due to be reviewed in November 2019. It has been reviewed in line with the Trust's Policy for the Development and Implementation of Procedural Documents and is being presented to the Trust Board for approval. The policy is attached at Annex B to this report.

Risk Management Strategy and Policy

6. The Trust's Risk Management Strategy and Policy was reviewed in January 2020; this review identified a significant amount of change required; therefore this is now scheduled to be presented to the Audit Committee in February and Board for approval in March.

Terms of Reference

7. At its meeting on 29 October 2019, the Nomination and Remuneration Committee considered proposed new Terms of Reference. These proposed new Terms of Reference are attached at Annex C to this report, for approval by the Trust Board.

8. The Charitable Funds Committee considered the need for new Terms of Reference at its meeting on 11 November 2019. These proposed new Terms of Reference are attached at Annex D to this report, for approval by the Trust Board.

9. The Trust Board discussed the establishment of a Staff Advisory Panel at its informal meeting on 17 December 2019. The proposed Terms of Reference for this new body are attached at Annex E to this report, for approval by the Trust Board.

Register of Interests

10. The Trust Board has agreed that the Register of Interests should be published on a quarterly basis. The Register of Interests for Q3 2019/20 is attached at Annex F to this report.

Philippa Harding
Director of Corporate Governance

London Ambulance Service NHS Trust

Business Continuity Management Policy

Document Control

Document Reference	TP006
Version	7.1
Approved by	Trust Board
Lead Director/Manager	Chief Operating Officer, Director of Ambulance Services
Author	Head of Business Continuity
Distribution list	Trust Board, Executive Committee, Senior Managers, All staff (via intranet)
Issue Date	01/02/20
Review Date	31/07/20

Change History

Date	Change	Approved by/Comments
07/01/20	Change to new policy format and update text to ISO22301:2019	
29/08/19	Approval of updated plan	
24/07/19	Annual review and update. Amendments to Governance structure, committee and role changes	
06/08/18	Format changes	
06/08/18	Update of role titles	
30/07/18	Comments & corrections following circulation to PMAG	
04/07/18	Amendments following comments	
10/06/18	Amendments and comments	
25/04/18	Format change in line with Trust guidelines. Addition of SIRO and IAO roles to responsibilities and planning sections. Update to reporting structure	
23/01/18	Amendments following further review against ISO22301:2102	
07/09/17	TP028 Plan re-written to align with ISO22301:2102	

Date	Change	Approved by/Comments
25/10/16	Document Profile and Control Update	
25/10/16	Minor amendments to Business Continuity Steering Group membership	
05/10/16	Document Profile and Control Update	
28/07/16	Some additions with terminology and minor changes nothing to change main body or meaning of the document	
21/06/16	Superficial changes of terminology	
18/05/16	Change some management titles since management restructure and terminology	
07/05/15	Document Profile and Control Update and minor corrections	
10/04/15	Amendment to 7.3 to reflect risks coming to SMT in the first instance	
10/03/15	Review and Update including changes in responsibilities. Changes to Appendix 1 in sections – 2, 6, I. In addition amendment to 7.3 to reflect risks coming to SMT in the first instance. Update to section 5 definitions	
03/02/14	Review and Update	
06/03/13	Minor changes required by SMT and Document Profile and Control update.	
18/02/13	Updated EPRRSG Terms of Reference added.	
15/02/13	Minor changes, formatting and Document Profile and Control update.	
31/01/13	Comments from IG Manager	
25/01/13	Comments from EPRRSG meeting 24/01/13	
09/01/13	Reviewed in line with ISO22301:2012	
13/07/12	Reformatted in line with TP/001	
09/03/12	Text font and style changed in line with TP/002	
02/02/11	EPBCSG approved Version	
02/02/11	Reviewed by EPBCSG and Updated by PW	
18/11/10	Review and Update	
31/8/07	Issued pending approval by RCAG	
02/08/07	Revised draft of new version agreed by BCSG	
08/03/07	Initial review and update of contents	
08/11/05	New policy	

1. Introduction - Policy Objective

1.1. London Ambulance Service (LAS) is the busiest emergency ambulance service in the UK and is the only London-wide NHS trust. It employs around 5,000 staff, who work across a wide range of roles, serving more than eight million people who live and work in the London area.

1.2. The service works closely with hospitals and other healthcare professionals, as well as with the other emergency services, and is, as a 'category one' responder, central to the emergency response to major incidents and terrorist threats in the capital.

1.3. NHS organisations, identified as 'category one' responders have a legal duty, under the Civil Contingencies Act 2004 and the Health and Social Care Act 2012, to have robust business continuity management (BCM) arrangements in place which will help them to maintain their critical functions if there is a major emergency or disruption. These requirements are also set out in the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR).

1.4. Having a robust business continuity management process allows an organisation to maintain standards during any disruption, or to recover to these standards as soon as possible. It is the organisation's responsibility to ensure it meets the legal requirements and core standards. This extends to services provided through partnerships or other forms of contractual arrangement.

1.5. All NHS organisations must use the NHS England Business Continuity Management Framework (2013) and the associated core standards in order to align themselves with the British Standard ISO 22301:2019 and fulfil all assurance processes. (NHS England Business Continuity Management Framework, 2013).

1.6. LAS must therefore be able to maintain continuous service levels in key services when faced with disruption. The LAS Business Continuity (BC) Policy provides details of the development of the Trust BC plans, identifying and managing risks that could disrupt normal service, and identifying any mitigating actions to promote organisational resilience.

1.7. The consequences of not having an effective Business Continuity Plan (BCP) in place could have serious implications including:

1.7.1. Failure to deliver key services to an acceptable level
1.7.2. Possibility of loss of life or injury
1.7.3. Loss of public confidence
1.7.4. Exposure to potential legal action.

1.8. The objective of this policy is to ensure business continuity within LAS is managed in line with the standards required within the Civil Contingencies Act 2004 and the Health and Social Care Act 2012, NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR and the NHS England Business Continuity Management Framework, 2013) and the associated core standards to align with the British Standard ISO 22301:2019.

2. Scope and Definitions

2.1. This policy is applicable to all Trust staff and applies to all services required to maintain the continuous delivery of an emergency pre hospital medical service to the population of London.

2.2. The Business Continuity Management Framework contains further detail regarding the business continuity management system for LAS

2.3. Definitions:

Business Continuity: The capability of an organisation to continue to deliver services at an acceptable predefined level following a disruptive incident

Business Continuity Management: A holistic management process that identifies potential threats to an organisation and the impact of those threats on business, and provides a framework for building organisational resilience with the capability of an effective response that safeguards the interests of its key stakeholders, reputation, brand and value creating activities

Business Continuity Management Framework: An overview of business continuity arrangements for maintaining effective and continued delivery of urgent and emergency care services during an event that directly affects the Trust, its buildings, technology or staff.

Business Impact Analysis: Process of analysing activities and the effect that a business disruption might have on them

Business Continuity Plan: Documented procedures that guide the organisation to respond, recover, and restore to a pre-defined level of operation following a disruption

Business Continuity Event: A business continuity event is an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery below acceptable predefined levels where special arrangements are required to be implemented until services can return to an acceptable level. (This could be a surge in demand requiring resources to be temporarily redeployed)

Business Continuity Critical Incident (Previously Internal Major Incident): A critical incident is any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions.

N.B. This is not a category previously used by LAS and has been introduced within the business continuity plan in line with the NHS England Framework

Business Continuity events and Critical Incidents will be managed through the Trust BC response plan

Major Incident: A major incident is any occurrence that presents serious threat to the health of the community disruption to the service or causes (or is likely to cause) such numbers or types of casualties, as to require special arrangements to be implemented by hospitals, ambulance trusts or primary care organisations.

Major Incidents will be managed through the Trust Incident Response Plan

Category 1 responders: A term defined under the UK's Civil Contingencies Act (CCA) 2004 as a person or body listed in Part 1 of Schedule 1 to the CCA which is required to prepare for emergencies in line with its responsibilities under the Act, which includes assessing local risks, implementing emergency plans and co-operating with other local responders to enhance co-ordination and efficiency

3. Accountabilities and Responsibilities

Chief Executive

3.1. Has overall responsibility and accountability for ensuring effective business continuity plans are in place and that the Board receives regular reports regarding business continuity including planning, assessment, training, exercises and audit.

Chief Operating Officer

3.2. Is the Accountable Emergency Officer and the designated executive lead for business continuity, responsible for ensuring the BCM process is being followed, and providing information and reports for the Board

Executive Leadership Team

3.3. Responsible for ensuring all of their areas of responsibility have up to date, effective business continuity plans, a designated lead is identified for each department and local training has been undertaken

Director of Ambulance Services

3.4. Chair of Emergency Planning and Resilience Strategy Group (EPRSG)

On call Strategic Commander (Gold)

3.5. Provides a 24-hour advisory and escalatory point of contact for the Duty Tactical Commander, coordinates the strategic response to the event and set specific aims and objectives

On call Tactical Commander (Silver)

3.6. Provides a 24-hour on call management response to a declared business continuity event, and coordinates the tactical response in line with strategic objectives and aims

Strategic and Tactical Advisors

3.7. Offer expertise, advice and support to the Strategic Commander and Tactical Commander as required

Departmental Leads/Assistant Directors of Operations

3.8. Responsible for ensuring identified leads are engaged in the BC process and supported in delivering local plans

Head of Business Continuity

3.9. Designated operational lead for business continuity:

3.9.1. Responsible for the development of the Trust Business Continuity Management System and Framework in line with National standards
3.9.2. Responsible for ensuring that the organisational BCM is completed, implemented, trained, exercised and audited
3.9.3. Chair of the Business Continuity Working Group
3.9.4. Ensures any National initiatives or changes are reported back to the Trust, via the EPRSG and action taken where necessary
3.9.5. Attend National Ambulance Business Continuity Group meetings

Local Business Continuity Leads

3.10. Responsible for the assessment, completion, implementation, maintenance, training and exercising of local BC plans within their own areas of responsibility, and act as local support/coordinator in response to a business continuity event

Senior Information Risk Owner

3.11. Responsible for ensuring that a business continuity strategy is in place for all critical information assets and critical processes, including those provided under service contract or agreement by third parties. Ensures that the policy is linked to the Trust business continuity management process

Information Asset Owner

3.12. Responsible for analysing the effect a disruption may have on their business function, liaising with the local business continuity lead and ensuring information security elements are considered and included in local business continuity plans where required

All staff

3.13. Be familiar with and follow local plans, be aware of their local action card, ensure their manager has their up to date contact details, attend training as required and participate in exercises as requested.

Emergency Planning and Resilience Strategy Group – (Chair – Director of Ambulance Services)

3.14. Ensures the development of, and approve, the Trust business continuity management policy, framework and business continuity plan for the Trust BCM:

3.14.1. Agrees overall corporate BCP
3.14.2. Monitors overall BCM against national standards
3.14.3. Considers and approves BC training and exercise programmes
3.14.4. Ensures all risks identified in the BCM process are included on the Trust risk register where necessary
3.14.5. Review business continuity events and ensure organisational learning is identified and shared

3.14.6. Escalate any business continuity issues to the appropriate forum
3.14.7. Provides business continuity progress reports for the Chief Operating Officer Quality and Assurance Meetings

Business Continuity Working Group

3.15. Develops and agrees local business continuity plans (BCP)

3.16. Supports the Head of Business Continuity in the development of a coordinated Trust wide BCP

3.17. Identifies business continuity training requirements and assists in local training

3.18. Identifies and develop local and Trust-wide business continuity exercises

3.19. Supports local areas in the delivery of the BCM

Chief Operating Officer Quality and Assurance Meeting

3.20. Receives and reviews papers from EPRSG. The EPRSG representative will highlight any issues or actions required as necessary

4. Business Continuity Management

4.1. The process for business continuity management at LAS follows the guidance set out in NHS Commissioning Board Business Continuity Management Framework (service resilience) and aligns to the international standard for business continuity (ISO 22301:2019), and is described below:

Plan-Do- Check- Act

4.2. In adopting the international standard for business continuity (ISO 22301:2019), the Trust will utilise the Plan-Do-Check-Act cycle for developing, implementing and improving the effectiveness of the BCMS. The four stages in this cycle are as follows;

4.2.1. Plan - Establish business continuity policy, procedures and objectives
4.2.2. Do - Implement and operate the business continuity policy, controls and procedure
4.2.3. Check - Monitor and review performance against the policy, objectives and standards and provide reports for review
4.2.4. Act - Maintain and Improve business continuity management by taking corrective action, based on the results of audit, review and event feedback

Risk Assessment

4.3. Any local or organisational risk will be identified during the business impact analysis process. All identified risks will be added to local risk registers, and reviewed and actioned as required as identified in the Business Continuity Framework. Risk assessments are completed in line with the organisational risk policy to identify both the likelihood and impact of risks.

4.4. Local risk management/mitigation strategies will be included within local business continuity plans where required.

Business Impact Analysis

4.5. The initial stage of the BCM process is the completion of a strategic business impact analysis, followed by an analysis of all areas within the organisation. Local BC leads for all departments will complete their local BIA(s) at the beginning of the process. The BIA will be reviewed annually, or following a service change or business continuity event. Further details are included in the Business Continuity Framework.

4.6. The BIA process will identify:

- 4.6.1. Potential risks and main threats to staffing levels, estate, infrastructure (including information systems and networks), providers/suppliers and service capacity and their impact
- 4.6.2. How long the service could continue before implementing emergency measures
- 4.6.3. How long emergency measures are sustainable before normal service would need to be resumed
- 4.6.4. Risk to the organisation if mitigation fails

Business Continuity Plans

4.7. Following completion of BIAs each area will develop a local BC plan

4.8. It is not possible to plan for every disruptive event, therefore local BC plans have been developed to provide guidance in managing the consequence – loss of or disruption to:

- 4.8.1. Estate
- 4.8.2. Infrastructure (telephony, power, water)
- 4.8.3. IM&T
- 4.8.4. Staffing
- 4.8.5. Supplies including vehicles

4.9. Identify measures to: reduce the likelihood of a disruption; reduce the period of disruption where possible and limit the impact of a disruption on other key services.

4.10. A Trust-wide BC plan will be developed from local plans which will ensure there is consistency of response and resource identification is not duplicated i.e. there is no competition in the identification of alternative space available.

4.11. The completed BC plan will be available for all staff on the Pulse in the EPRR, business continuity section. This will include all local plans/action cards and can be used as a reference for the Strategic Commander during a BC event.

4.12. Paper copies of the plans are stored in Gold suite at Waterloo HQ, Resilience and Specialist Assets Department at Cody Road and the Incident and Delivery Managers Office at Bow. It is the responsibility of the Head of Business Continuity to ensure that the paper copies are the current documents

4.13. Local areas will hold their own individual BC plan only, all new staff will be made aware of the plans at local induction.

4.14. Plans will be reviewed and updated annually, if there are any service changes or following a BC event.

4.15. All changes must be communicated to the Head of Business Continuity who is responsible for amending and updating the public document on the Pulse.

4.16. Following any change all previous paper copies must be destroyed and replaced with the up to date plan/card – document control on all pages of documents is essential to ensure this procedure is carried out – the current version number will be clearly identified on the Pulse

5. Implementation Plan

5.1. The policy will be posted on the Trust internet and intranet site, staff will be made aware of its existence via the Routine Information bulletin (RIB)

5.2. Business continuity awareness campaigns will be undertaken throughout the year which highlight the relevant policies and procedures

6. Competence (Education and Training)

6.1. All staff have access to information on the Pulse to improve understanding of the topic

6.2. Business Continuity Leads undertake mandatory business continuity training via e-learning

6.3. A business continuity awareness e-learning package is available to all staff on ESR. Uptake is monitored monthly and reviewed at the Business Continuity Working Group, local BC leads are responsible for promoting uptake within their departments

6.4. Specific local training sessions are coordinated and delivered by the Head of Business Continuity with the support of local BC Leads

6.5. An annual BC exercise programme is in place to test Trust and local plans in response to a variety of scenarios

7. Monitoring Compliance

7.1. A formal review of all aspects of BCM is conducted annually by the Head of Business Continuity to ensure that all plans, processes and governance arrangements are current and accurate. This is reviewed at ERPSG and included in the annual NHSE EPRR Assurance review

7.2. All updated BIAs and plans are reviewed annually and assessed against key criteria by the Head of Business Continuity – any issues are addressed with the local BC lead

7.3. Completion and update of plans, and uptake of training are monitored and reported bi-monthly to the Business Continuity Working Group, and quarterly to EPRSG

7.4. Reporting, investigation and review of business continuity events is monitored through the Business Continuity Working Group bi-monthly and EPRSG monthly

7.5. Actions required following a BC event are coordinated by the Head of Business Continuity and monitored through the Business Continuity Working Group and EPRSG

8. Effectiveness and Reporting

8.1. The following key performance indicators for business continuity are monitored and reviewed quarterly at EPRSG:

8.1.1. Local business continuity lead identified
8.1.2. Engagement of the local business continuity lead in the BCM process (attendance at Business Continuity Working Group)
8.1.3. Completion and update of local business impact analysis
8.1.4. Completion and update of local business continuity plan
8.1.5. Departmental training uptake

9. Policy Review

9.1. The policy is reviewed annually in June by the Business Continuity Working Group and EPRSG, or as a result of significant organisational learning, change in guidance or process.

10. Equality Impact Assessment Statement:

10.1. This policy has been reviewed in line with the Equality Act 2010 which places a duty on the Trust to have due regard to the need to:

10.1.1. Eliminate discrimination, harassment and victimisation.
10.1.2. Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.
10.1.3. Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.
10.1.4. The Act sets out nine protected characteristics that apply to the equality duty, which must be considered in the writing of all documents.

11. References

11.1. This policy has drawn on guidance from:

11.1.1. The Business Continuity Institute (2013) *Good Practice Guidelines 2013 – Global Edition – A Guide to Global Good Practice in Business Continuity*
Available online at: www.thebci.org

11.1.2. British Standards Institute (2012) Societal security – *Business Continuity Management Systems - Requirements*
Available from the Trust Resilience Team

11.1.3. British Standards Institute (2013) Societal security – *Business Continuity Management Systems – Guidance*
Available from the Trust Resilience Team

11.1.4. HMG (2004) *The Civil Contingencies Act (2004)*, Her Majesties Stationary Office.
Available online at:
http://www.legislation.gov.uk/ukpga/2004/36/contents

11.1.5. HMG (2004a) *Emergency Preparedness – Guidance on Part 1 of the Civil Contingencies Act 2004, its associated regulations and non-statutory arrangements*, Her Majesties Stationary Office

Available online at:
https://www.gov.uk/government/publications/emergency-preparedness

11.1.6. NHS Commissioning Board (2013) *NHS Commissioning Board Core Standards for Emergency Preparedness, Resilience and Response (EPRR)*
Available online at: http://www.england.nhs.uk/wp-content/uploads/2013/02/eprr-standards.pdf

11.1.7. NHS Commissioning Board (2013a) *NHS Commissioning Board Business Continuity Management Framework (service resilience)*
Available online at: http://www.england.nhs.uk/wp-content/uploads/2013/01/bus-cont-frame.pdf

London Ambulance Service NHS Trust

Anti-Fraud, Bribery and Corruption Policy

Document Control

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16/01/20	To comply with the Development and Implementation of Procedural Documents Policy	
28/10/19	Periodic update of policy	
13/12/16	Document Profile and Control update	
07/12/16	Minor amendment to Appendix 4 S.9	
28/11/16	Amended to reflect comments from PMAG	
13/09/16	Periodic update of policy	
02/10/14	Document Profile and Control update	
10/09/14	The two IT sections merged into one (4.5)	
02/09/14	Document Profile and Control page update	
02/09/14	Further changes	
29/08/14	Adapted to comply with LAS standard format	
24/07/14	First draft agreed by Finance Committee	

1. Introduction - Policy Objective

1.1 This policy must be read and followed in conjunction with the London Ambulance Service NHS Trust (LAS) Disciplinary Policy and Freedom to speak up; raising concerns (Whistleblowing) Policy.

1.2 This document identifies the London Ambulance Service NHS Trust (LAS) policy and framework for dealing with fraud. It comprises three elements:-

1.2.1 Anti-Fraud, Bribery and Corruption;
1.2.2 What individuals should do if they suspect fraud; and
1.2.3 An indication of how fraud will be investigated (the detail is contained in the Counter Fraud & Corruption Manual published by the NHS Counter Fraud Authority);

1.3 It is a part of the corporate governance framework which governs the actions of the LAS and promotes public service values.

1.4 The LAS has a zero tolerance policy towards fraud and bribery. The LAS will always seek the appropriate sanctions and redress and explore all opportunities available should fraud occur.

1.5 The overall aims of this policy are to:

1.5.1 Improve the knowledge and understanding of everyone in the Trust, irrespective of their position, about the risk of fraud, bribery and corruption within the organisation and its unacceptability.

1.5.2 Assist in promoting a climate of openness and a culture and environment where staffs feel able to raise concerns sensibly and responsibly.

1.5.3 Set out the Trust's responsibilities in terms of the deterrence, prevention, detection and investigation of fraud, bribery and corruption.

1.5.4 Ensure the appropriate sanctions are considered following an investigation, which may include any or all of the following:

1.5.4.1 Criminal prosecution
1.5.4.2 Civil prosecution
1.5.4.3 Internal/external disciplinary action (including professional/regulatory bodies)

1.6 The LAS as an organisation is committed to the seven principles of public life, set out in the Nolan Committee report. In essence these are:-

Selflessness: - Decisions must be made solely in terms of public interest, not in order to gain personal financial or other benefits.

Integrity: - Members, Directors and staff should not place themselves under any obligation to third parties.

Objectivity: - In carrying out LAS business all appointments, contracts and recommendations must be made on merit.

Accountability: - Members, Directors and employees of the LAS are accountable for their decisions and actions.

Openness: - The LAS Board and Directors will be as open as possible on all decisions and action taken.

Honesty: - Directors and staff have a duty to declare any private interests which may impact on their LAS duties.

Leadership: - The LAS Board and Directors will support these principles by leadership and example.

1.7 The policy is supported by a detailed procedure as defined in the NHS Counter Fraud and Corruption Manual issued by the NHS CFA.

Demonstrating Commitment

1.8 The commitment of the LAS to probity and public service values includes

1.8.1 the promotion of an ethical environment.
1.8.2 the maintenance of an Audit Committee with clear terms of reference and unrestricted scope.
1.8.3 the operation of a reward and remuneration committee.
1.8.4 the use of clearly defined and documented policies.
1.8.5 compliance with statutory financial reporting requirements.
1.8.6 operation of an effective accounting and budgetary control system.
1.8.7 an adequate and effective internal audit function.
1.8.8 putting in place appropriate internal controls.
1.8.9 holding regular public meetings.
1.8.10 investigating all cases of alleged fraud and corruption.
1.8.11 nomination of a Local Counter Fraud Specialist (LCFS).
1.8.12 be as open as possible on all decisions and action taken.

1.9 This commitment impacts on the day to day activities of Directors, staff and contractors through the operation and regular review of the following features:-

Activity	Review by Board	Responsible officer
Maintenance of Standing Financial Instructions.	Annual	Chief Finance Officer
Maintenance of Standing Orders	Annual	Company Secretary
Audit Committee/ Remuneration Committee	At least annual	Company Secretary
Decisions Reserved for Board	Annual	Chief Finance Officer/ Company Secretary
Scheme of Delegation	Annual	Chief Finance Officer/ Company Secretary
Maintenance of Register of Interests	-	Company Secretary

Activity	Review by Board	Responsible officer
Maintenance of Register of Declarations of Gifts and Hospitality	-	Company Secretary
Issue of Standards of Business Conduct HSG (93)5 to all staff (within this HSG, the Bribery Act 2010 replaces the 'Prevention of Corruption Acts '1889 - 1916')	-	Chief Executive as nominated officer but may discharge their duties to an approved officer of a shared service provider.
Annual Declaration of Interests by all Board Members	-	Company Secretary
Undertaking adequate checks on the recruitment of staff (including temporary staff)	-	Director of People and Culture as nominated officer but duties may be discharged to an approved officer of a shared service provider.
Fraud Log	Quarterly via Audit Committee meetings	Chief Finance Officer

1.10 In addition the Board tries to ensure that a risk and fraud awareness culture exists in the LAS.

2. Scope and Definitions

2.1 This policy covers the Chairman, Chief Executive, Directors, Members and all employees of the LAS (including locum, bank and agency staff). It also applies to external stakeholders e.g. contractors, consultants, vendors as well as the volunteers, visitors and patients of the LAS.

2.2 This policy also covers all external persons with whom the LAS conducts business and all other organisations providing a service to the LAS, hereafter referred to as contractors.

2.3 The policy is supported by additional guidance on:

2.3.1 Whom to contact if fraud is suspected (Appendix 1)
2.3.2 What to do if fraud is suspected (Appendix 2)
2.3.3 With further guidance on the investigation of irregularities available in a separate document.

2.4 The approach the LAS will take in addressing fraud and corruption will be inclusive, professional, comprehensive, fair, balanced, cost effective and specialised.

3. Accountabilities and Responsibilities

3.1 The Trust's anti-fraud arrangements will be overseen by the Audit Committee who will agree the work plan for Anti-Fraud each year.

Chief Executive

3.2 The Chief Executive has the overall responsibility for funds entrusted to the organisation as

the accountable officer. This includes instances of fraud, bribery and corruption. The Chief Executive must ensure adequate policies and procedures are in place to protect the organisation and the public funds entrusted to it.

Chief Finance Officer

3.3 The Chief Finance Officer is the responsible officer for fraud, bribery and corruption.

3.4 The Chief Finance Officer (CFO) is provided with powers to approve financial transactions initiated by directorates across the organisation.

3.5 The CFO prepares, documents and maintains detailed financial procedures and systems and ensures that they incorporate the principles of separation of duties and internal checks to supplement those procedures and systems.

3.6 The CFO will report annually to the Board on the adequacy of the internal financial control and risk management as part of the Board's overall responsibility to prepare a statement of internal control for inclusion in the NHS body's annual report.

3.7 The responsibility for initiating an investigation into any fraudulent or corrupt activity against the LAS rests with the Chief Finance Officer, who will delegate any specific case to the LCFS or the NHS Counter Fraud Authority as appropriate.

3.8 The Chief Finance Officer has responsibility for ensuring the following are notified as appropriate: -

3.8.1 NHS Counter Fraud Authority (NHS CFA)
3.8.2 Nominated Local Counter Fraud Specialist (LCFS)
3.8.3 Chief Executive.
3.8.4 Audit Committee.
3.8.5 Board of the LAS.
3.8.6 Internal Audit.
3.8.7 Nominated Officer of Shared Service Provider (if appropriate).
3.8.8 Police.
3.8.9 External Audit.
3.8.10 Pension Agency.
3.8.11 Department of Health and Social Security.
3.8.12 NHSI (NHS Improvements)

3.9 It is also the responsibility of the Chief Finance Officer to assess and quantify any loss arising and to instigate a process of recovery through civil proceedings, restitution or recovery via a claim on pension contributions.

3.10 In addition the Chief Finance Officer will have responsibility for maintaining a register of reported frauds (Fraud Log) and ensure that details contained within it are regularly reported to Audit Committee.

Line Managers

3.11 The role of line managers is:

3.11.1 To contact the Local Counter Fraud Specialist as soon as they become aware of any concerns which may be related to a suspected fraud.
3.11.2 Ensure that during recruitment of new staff, all appropriate pre-employment checks are carried out for all appointments, including temporary staff.

3.11.3 Ensure that all staff are aware of and understand the Standards of Business Conduct for NHS Staff HSG(93)5 (as amended by the Bribery Act 2010).
3.11.4 Ensure all staff are aware of the need to declare gifts and hospitality that have a monetary value of £25 and over – refer to Standing Orders on The Pulse.
3.11.5 To be aware of and seek guidance where appropriate on the links between this policy and other associated policies (see page 2 for links with other documents).

3.12 Line managers should be alert to the possibility that unusual events or transactions could be symptoms of fraud. The following are some examples of circumstances that may indicate fraud and should therefore put people on the alert:

3.12.1 Altered documents (correcting fluid, different pen or handwriting)
3.12.2 Claim form details not readily checkable
3.12.3 Changes in normal patterns, of e.g. cash takings or travel claim details
3.12.4 Text erratic or difficult to read or with details missing
3.12.5 Delays in completion or submission of claim forms and the like
3.12.6 Lack of vouchers or receipts in support of expense etc claims
3.12.7 Staff seemingly living beyond their means
3.12.8 Staff under constant financial or other stress
3.12.9 Staff choosing not to take annual leave (and so preventing others becoming involved in their work), especially if solely responsible for a "risk" area
3.12.10 Complaints from public or staff
3.12.11 Always working late
3.12.12 Refusal of promotion
3.12.13 New staff not staying long
3.12.14 Insistence on dealing with a particular individual

Staff

3.13 The role of line staff is:

3.13.1 Complying with the policy and code of conduct
3.13.2 Reporting suspicions of fraud and not tipping off the member of staff

Human Resources

3.14 Following the instigation of any investigation by the Local Counter Fraud Specialist, Human Resources should be appraised by either the Chief Finance Officer or the Local Counter Fraud Specialist to offer advice and assistance on relevant aspects of employment law and the instigation of the LAS Disciplinary Policy.

3.15 People and Culture are responsible for ensuring the appropriate use of the LAS's Disciplinary Procedure. The Director of People and Culture will advise those involved in the investigation in matters of employment law and in other procedural matters, such as disciplinary and complaints procedures, as requested. Close liaison between the LCFS and People and Culture will be essential to ensure that any parallel sanctions (i.e. criminal and disciplinary) are applied effectively and in a coordinated manner.

3.16 Where an investigation results from an allegation that has been received outside of the approved route, the Director of People and Culture will be responsible for agreeing how and when to inform the source of the 'allegation' of the outcome of the investigation. This decision and all related correspondence should be documented and retained on file for an appropriate period. The individual(s) concerned should be reminded of the importance of reporting allegations via the LAS's formal process and directed to the relevant guidance.

Information Technology

3.17 The Computer Misuse Act 1990 defines computer related fraud as private gain or benefit by:

3.17.1 altering computer input in an unauthorised way;
3.17.2 destroying, suppressing or stealing output;
3.17.3 making unapproved changes to stored information; or
3.17.4 amending or misusing programs (excluding virus infections).

3.18 This includes private gain or benefit by inappropriate Internet or e-mail use or through unapproved access to a system or data, including the use of other people's accounts.

3.19 Where there is actual or suspected fraudulent use of information technology, this should be reported to the Information Security Manager or equivalent and the LCFS.

3.20 The Chief Finance Officer must be alerted in all cases where there is suspicion that IT is being used for fraudulent purposes.

3.21 People and Culture must be alerted if there is a suspicion that an employee is involved.

Local Counter Fraud Specialist

3.22 The LAS Local Counter Fraud Specialist service is provided by Grant Thornton UK LLP. The lead LCFS is Mark D Kinsella, who can be contacted via email at Mark.D.Kinsella@uk.gt.com, counter.fraud@nhs.net or via telephone on 07415 939401.

3.23 The investigation of fraud will be undertaken by the LAS Local Counter Fraud Specialist or in conjunction with the NHS Counter Fraud Authority where this is in line with national protocols. The investigation will be undertaken in accordance with the NHS Counter Fraud and Corruption Manual. The LCFS will update the Chief Finance Officer at all appropriate stages of the investigation.

3.24 The LCFS will amongst other duties:

3.24.1 Ensure that the Chief Finance Officer is kept appraised of all cases.
3.24.2 In consultation with the Chief Finance Officer and the NHS Counter Fraud Authority will report any case to the Police as necessary.
3.24.3 Report the outcome of the investigation to the NHS Counter Fraud Authority and Chief Finance Officer.
3.24.4 Ensure appropriate liaison with People and Culture where necessary. People and Culture will be informed in all cases where a LAS employee is a suspect.
3.24.5 Ensure that any system weaknesses identified as part of the investigation are followed through with management.

Internal and External Audit

3.25 The role of internal and external audit includes reviewing controls and systems and ensuring compliance with financial instructions. Internal and External auditors have a duty to pass on any suspicions of fraud, bribery or corruption to the Local Counter Fraud Specialist (LCFS).

Management and the NHS Counter Fraud Authority

3.26 With regard to fraud, financial irregularity and corruption, it is one of the fundamental

duties of management to put in place systems which will ensure:-

- the security of assets
- compliance with laws and regulations
- effective financial stewardship and will demonstrate the probity of transactions
- the reduction of fraud to a minimum.

3.27 Consequently all Directors and Managers have a responsibility for ensuring that all the systems over which they exercise control comply with the principles outlined.

3.28 Managers must promote an anti-fraud culture within their team and ensure employees believe that dishonest acts will be detected and investigated. To this end they must:

- Participate in in-house training programs covering fraud, fraud detection and fraud prevention.
- Ensure staff understand that internal controls are designed and intended to prevent and detect fraud.
- Encourage staff to report suspected fraud directly to the Chief Finance Officer or the Local Counter Fraud Specialist (LCFS) for investigation without fear of disclosure or retribution.

3.29 The NHS Counter Fraud Authority has responsibility for all policy and operational matters relating to the prevention, detection and investigation of fraud, bribery and corruption in the NHS and any investigations will be handled in accordance with the NHS CFA guidance.

Summary of Actions

3.30 Fraud, financial irregularity, bribery and corruption are criminal acts and the Governing Body is committed to eliminating any such acts within the LAS.

3.31 Where a Director, Member, employee, third party contractor or member of the public is suspected of fraud, financial irregularity or corruption he/she will be subject to investigation by the Local Counter Fraud Specialist (LCFS), the NHS Counter Fraud Authority, and the police. The investigation will be undertaken in conjunction with the relevant disciplinary policy, which may lead to dismissal and prosecution.

3.32 Where a police or fraud investigation is instigated, this is separate from any internal process. Should more than one investigation be commissioned, these can run concurrently but will be distinctly separate.

3.33 Where the LAS incurs a loss arising from theft by, or the fraudulent or corrupt act of a director, member, employee, third party contractor or member of the public; recovery of losses will always be sought.

3.34 Requests for references for employees dismissed for reasons connected with fraud, financial irregularity or corruption must be dealt with by the Director of People and Culture or a delegated People and Culture officer.

3.35 The police will be contacted promptly as soon as theft is identified and notified in accordance with the internal security management policy

Fraud

3.36 Fraud is defined as ‘dishonest conduct with the intention to make a gain, or cause a loss or the risk of a loss to another’. The new Fraud Act 2006 came into force on the 15th

January 2007. The Act introduces provision for a general offence of fraud which is broken into three main sections;

- Fraud by false representation
- Fraud by failing to disclose information
- Fraud by abuse of position

Fraud by false representation

3.37 A representation is defined as false if it is untrue or misleading and the person making it knows that it is, or might be, untrue or misleading. Representation can be stated by words or communicated by conduct i.e. written, spoken or by electronic means. Examples of fraud by false representation include falsifying time sheets or expense claims.

Fraud by failing to disclose information

3.38 A fraud will have been committed if a person fails to declare information which he/she has a legal duty to disclose. There is a requirement that the person acts dishonestly and intends to make a gain for himself/herself, cause a loss to another or expose another to a risk of loss. An offence is committed under this section of the act where a job applicant fails to disclose a criminal conviction.

Fraud by abuse of position

3.39 Fraud by abuse of position requires a person who is in a privileged position to act dishonestly by abusing the position held; and by doing so, fails to disclose to another person, information which he/she is legally required to disclose. The dishonest act must be with the intention of making a gain for himself / herself or another. Alternatively, it may be with the intention of causing a loss or risk of loss to another. The offence may be committed by omitting to make a declaration as well as by an act. An example covered by this section is where a person who is employed to care for an elderly or disabled person has access to that person's bank account and abuses their position by removing funds for their own personal use.

3.40 The introduction of the Fraud Act 2006 does not prevent the prosecution of offences under the various Theft Acts and Forgery and Counterfeiting Act, e.g. theft, counterfeiting and falsification of documents.

Theft

3.41 A person is guilty of theft if he dishonestly appropriates property belonging to another with the intention of permanently depriving the other of it. The Local Security Management Specialist (LCFS) does not deal with theft cases – this would be the LSMS.

Corruption

3.42 Corruption is defined (in the context of the Prevention of Corruption Acts) as the offering, giving, soliciting or acceptance of an inducement or reward which may influence the action of any person. Bribery, a form of corruption, is an act implying money or gift giving that alters the behaviour of the recipient.

3.43 The Bribery Act 2010 replaces the fragmented and complex offences at common law and in the Prevention of Corruption Acts 1889-1916.

Bribery

3.44 There is no specific definition within the Bribery Act 2010 of this term. The Act however does set out four offences of bribery from which a definition can be inferred as a financial or other type of advantage that is offered or requested intending to induce another person to perform improperly one of their functions in their position of trust or responsibility, or as a reward for improper performance.

In essence, bribery is offering an incentive or reward to someone to do/for doing something that they would not normally do.

3.45 There are four offences of bribery within the Bribery Act 2010:

- Two general offences covering the offering, promising or giving of an advantage, and the requesting, agreeing to receive or accepting of an advantage;
- A discrete offence of bribery of a foreign public official to obtain or retain business or an advantage in the conduct of business;
- A new offence of failure by a commercial organisation to prevent a bribe being paid for or on its behalf;

3.46 A legal defence within the Bribery Act 2010 requires organisations to demonstrate that they have "adequate procedures" in place to prevent any bribery from occurring. To demonstrate that the LAS has sufficient and adequate procedures in place and to demonstrate openness and transparency, all individuals working for the LAS are required to comply with the requirements of this policy.

Examples of Bribery

3.47 The Bribery Act 2010 outlines the offences of bribery as the receipt or acceptance of a bribe, or the offer to, promise or giving of a bribe, which assists in obtaining/ retaining business or financial advantage, or the inducement or reward of someone for the improper performance of a relevant function. There are however no set types of bribery and there is huge variation in the types of scenarios and circumstances where bribery could occur. A non-exhaustive list of examples of where bribery could take place is as follows:

3.48 Offering a bribe

- You offer a potential client tickets to a major sporting event, but only if they agree to do business with the LAS.

3.49 Receiving a bribe

- A supplier gives your nephew a job but makes it clear that in return they expect you to use your influence in the LAS to ensure that it continues to do business with them.
- Someone responsible for awarding an employment contract is offered gifts and/or hospitality by one of the candidates or someone linked to them to ensure that the job is offered to the candidate.
- Someone responsible for booking bank or agency staff is offered lavish gifts and/or hospitality by an agency to ensure their agency staff are booked by the LAS.
- Someone responsible for choosing suppliers (medical or non-medical) or awarding business contracts is offered gifts and/or hospitality by an existing/new supplier, contractor or business to ensure they are selected as a supplier.
- Someone associated with the purchasing of drugs and/or the selection of approved drugs to the LAS Formulary is offered gifts, hospitality and/or paid expenses by a medical representative or Drugs Firm to ensure their drugs are purchased and/or added to the Formulary for prescribing by the LAS.

- Someone associated with the prescribing of drugs is offered gifts and/or hospitality by a medical representative or Drugs Firms to ensure they prescribe their drugs.
- Someone associated with the provision of training is offered gifts and/or hospitality by an external training company to ensure they are selected to provide training at the LAS.

Financial Irregularity

3.50 This may include any of the above descriptions.

3.51 These overview definitions are supported by more detailed narrative which can be found in the NHS Counter Fraud and Corruption manual. A copy is held by the Chief Finance Officer and the Local Counter Fraud Specialist (LCFS).

3.52 Fraud or financial irregularity also covers the alleged misuse of the resources of the LAS or any resources which the LAS manage on behalf of others.

4. Policy content

Approach to Countering Fraud

4.1 The NHS Counter Fraud Authority's "standards for providers" consists of individual standards under "four key principle" headings. The four key principles have been designed to incorporate the NHS national counter fraud strategy objectives for which the counter fraud services had to comply prior to the Health and Social Care Act.

4.1.1 Strategic Governance – This section sets out the standards in relation to the organisation's strategic governance arrangements. The aim is to ensure that anti-crime measures are embedded at all levels across the organisation.

4.1.2 Inform and Involve – This section sets out the requirements in relation to raising awareness of crime risks against the NHS and working with NHS staff, stakeholders and the public to highlight the risks and consequences of crime.

4.1.3 Prevent and Deter – This section sets out the requirements in relation to discouraging individuals who may be tempted to commit crimes against the NHS and ensuring that opportunities for crime to occur are minimised.

4.1.4 Hold to Account – This section sets out the requirements in relation to detecting and investigating crime, prosecuting those who have committed crimes and seeking redress.

4.2 The creation of an anti-fraud culture requires the commitment of staff at all levels and in all areas of activity to be vigilant and to report matters that indicate fraudulent activity. Guidance on this aspect is provided in Appendix 1 of supporting guidance to this policy.

4.3 The principal mechanisms in place to prevent fraud include:

- Standing Financial Instructions (SFIs)
- Standing Orders (SOs)
- Management control processes, including specific controls such as segregation of accounting responsibilities and authorisation procedures.
- Disciplinary Policy
- Freedom to speak up; raising concerns (Whistleblowing) Policy

Duty of Directors, staff and contractors

4.4 All Directors, staff and contractors have a duty to protect the assets of the LAS. Assets include information and intellectual property as well as tangible items.

4.5 Each and every Director, member of staff and contractor of the LAS has a responsibility to ensure that any suspected incidence of fraud, financial irregularity or corruption is identified and reported appropriately.

4.6 Any Director, member of staff or contractor who is aware of, but does not report any suspected fraudulent or corrupt act is condoning the act.

4.7 It should be noted that all Directors, staff and primary care contractors have a duty to comply with HSG (93)5 “Standards of Business Conduct for NHS Staff” (as amended by the Bribery Act 2010).

4.8 Staff are expected to act in accordance with the standards laid down by their Professional Institutes where applicable.

4.9 The LAS Standing Financial Instructions and Standing Orders place an obligation on all LAS staff and Non-Executive Directors to act in accordance with best practice. Non-Executive Directors are subject to the same high standards of accountability and are required to declare and register any interests that might potentially conflict with those of the LAS.

4.10 All budget holders have access to the Financial Procedures and Policy Manual to guide them in financial matters, and all Finance staff have a special responsibility to ensure that budget holders and their staff act responsibly in the use of their budgets.

Notification Requirements

4.11 Where a Director, member of staff or contractor suspects that a theft, financial irregularity, fraud or corrupt act has taken place, they should inform either the Director of Finance or the Local Counter Fraud Specialist (LCFS) immediately. Any unfounded or malicious allegations will be subject to a full investigation and appropriate disciplinary action.

4.12 If the alleged irregularity concerns the Chief Finance Officer an approach may be made directly to the Chief Executive. Where the alleged irregularity concerns the Chief Executive, the approach should be made to the Chairman of the LAS.

4.13 The Chief Finance Officer or the Local Counter Fraud Specialist will have the matter investigated according to the procedure as set out in the NHS Counter Fraud and Corruption Manual. Any information received will be treated as confidential. As soon as it appears that the matter may be dealt with under the LAS Disciplinary Policy, appropriate information will be passed to the People and Culture Department for consideration, and an investigation will be initiated as required. At this point, if appropriate, two investigations will be run in tandem.

4.14 Individual(s) concerned will be required to submit a signed statement and may be required to appear as witness (es) in any subsequent formal hearing or criminal proceedings.

Alternative Disclosure

4.15 An employee may contact the National Fraud and Corruption Reporting Line (Powered by Crimestoppers) on 0800 028 40 60 or by completing an online form via

www.reportnhsfraud.nhs.uk. This provides an easy alternative route of reporting and all telephone calls are dealt with by experienced call handlers, who will ensure that concerns are referred to the LAS LCFS and dealt with in the strictest confidence.

4.16 An employee may choose instead to contact the charity 'Protect' (formerly Public Concern at Work) on 020 3117 2520 who will offer the employee advice on how to proceed.

4.17 An employee may refer to the Whistleblowing Policy and follow the procedures set out in that document.

Outline of investigation process

4.18 Appendix 'B' describes the LAS's intended response to a reported suspicion of fraud. The following will be considered:

- No case to answer no evidence of fraud found;
- No evidence of fraud found but system controls need to be strengthened;
- No evidence of fraud found but matter needs to be referred to HR for disciplinary sanction to be considered;
- Reasonably held suspicion/information/evidence of suspected fraud received requiring criminal investigation.

No case to answer

4.19 The LCFS will inform the Chief Finance Officer that no fraudulent action has been identified.

No evidence of fraud found but system controls need to be strengthened

4.20 The LCFS will inform the Chief Finance Officer.

4.21 A concluding report will be issued with recommendations to strengthen controls in identified areas of weakness. This report will be distributed in accordance with the requirements outlined in the NHS Counter Fraud & Corruption Manual. The recommendations will be followed up by the LCFS as part of future fraud prevention work.

4.22 In most cases any work that is undertaken to strengthen controls in identified areas of weakness should not involve the disclosure of personal information or information relating to why policies or systems are being changed.

4.23 No evidence of fraud found but the referral is returned to People and Culture for potential disciplinary sanction to be considered.

4.24 The LCFS will inform the Chief Finance Officer.

4.25 If the LCFS does not find evidence of fraud but a breach of policy/procedures may have occurred, the LCFS will meet with a member of People and Culture to discuss the findings and pass on the file of evidence gathered to date.

4.26 The LCFS will take no further part in any additional investigation undertaken by HR regarding a suspected breach of procedures. A concluding report will be issued with recommendations to strengthen controls in identified areas of weakness. This report will be distributed in accordance with the requirements outlined in NHS Counter Fraud &

Corruption Manual. The recommendations will be followed up by the LCFS as part of future fraud prevention work.

Case to answer; criminal investigation undertaken and appropriate sanction considered

4.27 The LCFS will liaise with the Chief Finance Officer and conduct an investigation in accordance with investigative legislation such as the Police and Criminal Evidence Act 1984 (PACE) and the Criminal Procedure and Investigations Act (CPIA). Instructions outlined in the NHS Counter Fraud and Corruption Manual must be followed. Confidentiality will be respected during the course of the investigation.

4.28 Criminal investigations will be undertaken in a timely and professional manner so that the pursuit of other potential sanctions is not compromised.

4.29 Regular case meetings will be held so that the LCFS can keep the Chief Finance Officer and the designated People and Culture officer updated as the investigation progresses and discuss any potential sanctions that may be pursued.

4.30 If parallel sanctions are being undertaken, the LCFS will meet regularly with the People and Culture investigating officer to share information where necessary and lawful to avoid any duplication of effort. An investigation plan setting out the requirements for the parallel sanctions will be established and maintained throughout the investigation process.

4.31 In liaison with the Chief Finance Officer, People and Culture, the relevant NHS CFS Information Management Officer and LCFS, the LAS will consider the following three sanctions in cases where there is prima facie evidence of NHS fraud:

- Criminal – A criminal sanction is pursued where evidence of offences has been obtained so that relevant punitive sanctions and redress can be sought. This sanction can only be pursued if agreed by the Chief Finance Officer and in their absence the Chief Executive.

- Civil – Where it is cost-effective and desirable for the purpose of deterrence, it may be decided that civil redress is the most appropriate course of action. It is then the responsibility of the LAS to use the civil law to recover any losses.

- Disciplinary – Disciplinary procedures are designed to test whether a person should be permitted to practice or continue their employment. Recovery should be considered whenever this action is pursued and the organisation has suffered a financial loss due to inappropriate actions. The disciplinary policy will be followed in these cases. Those conducting disciplinary hearings should never make an express or implied statement that criminal proceedings will not be undertaken. Dismissal of an employee need not wait until the conclusion of any simultaneous criminal sanction that the LCFS may be undertaking.

4.32 Either one or a combination of these sanctions can be pursued. This will be assessed on a case-by-case basis.

5. Implementation Plan

IMPLEMENTATION PLAN				
Intended Audience	This policy applies to all staff			
Dissemination	The policy is to be made available on The Pulse and the LAS Website			
Communications	Staff will be informed about this policy through an announcement on the RIB			
Training	Training is not considered necessary			
Monitoring:				
Aspect to be monitored	**Frequency of monitoring AND Tool used**	**Individual/ team responsible for carrying out monitoring AND Committee/ group where results are reported**	**Committee/ group responsible for monitoring outcomes/ recommendations**	**How learning will take place**
Any activation of this policy will be discussed with the LCFS	Annually Preparation of report in conjunction with LCFS	Financial Controller to report findings to Audit Committee and Finance & Investment Committee	Audit Committee	Local bulletins; Intranet pages within LAS; Discussions with LCFS Reports to Executive Committee

6. Competence (Education and Training)

6.1 The LCFS is responsible for ensuring that key members of the LAS staff are aware of this policy, its requirements and the LAS initiatives to counter fraud through on-going awareness training.

6.2 Staff will be advised as part of the LAS induction training programme of the contents of this policy.

6.3 All LAS staff, where possible, should be provided with information about this policy and the part they have to play in the LAS' efforts to counter fraud.

7. Monitoring Compliance

7.1 The policy will be monitored by the Chief Finance Officer and Audit Committee of the LAS who will receive regular reports, including an annual report, from the Local Counter Fraud Specialist.

7.2 In addition, the Local Counter Fraud Specialist will submit an annual Self-Assessment in the form of a Self Review Toolkit (SRT), agree the self-assessment with the Chief Finance Officer and submit to the NHS CFA. The LCFS will support the LAS in any Quality

Assessment (QA) undertaken by the NHS CFA.

7.3 The LAS will be monitoring the number of cases referred by managers and staff to measure the effectiveness of the policy

8. Effectiveness and Reporting

8.1 The Local Counter Fraud Specialist will prepare reports for the Audit Committee on the reactive and proactive work being done with in the LAS.

9. Policy Review

9.1 This policy will be reviewed in November 2021 or as a result of significant organisational learning, change in law or best practice.

10. Equality Impact Assessment Statement:

10.1 London Ambulance Service (LAS) is committed to ensuring fair and accessible services for everyone who use the LAS our patients and our people who work for us. The Equality Act 2010 requires the LAS to take a proactive approach to equality and diversity.

10.2 The general equality duty requires LAS to: eliminate unlawful discrimination, harassment and victimisation advance equality between all people foster good relations between communities, tackling prejudice and promoting understanding.

10.3 This Policy has been written to deliver on this commitment and the general equality duty, by setting out how we will work towards creating a workplace where dignity and respect are the norm in the workplace. Where everything we do and say demonstrates Our Values and Behaviours, in order to actively tackle prejudice, recognise, acknowledge, accept and celebrate our differences.

10.4 The Equality Impact Assessment demonstrates there is no detriment to any protected characteristic group.

11. References

11.1. This policy has drawn on guidance from:

11.1.1. NHS Counter Fraud Guidelines
https://cfa.nhs.uk/fraud-prevention/fraud-guidance

Appendix 1

Guidance to all LAS Staff (Including bank/temporary/agency) and Contractors

What It Includes;	What to do:
FRAUD When a person commits theft (property / money) enabled by making a false representation.	You must only discuss your suspicions or any information or evidence you have identified with either: **Contact the Chief Finance Officer** **Lorraine Bewes OBE** Landline: 020 7783 2793 Email: Lorraine.bewes@lond-amb.nhs.uk **or**
BRIBERY / CORRUPTION Where someone is influenced by bribery, payment or benefit in kind to unreasonably use their position to give some advantage to another.	**Contact your Local Counter Fraud Specialist provided by Grant Thornton UK LLP:** **Mark Kinsella** Landline: 020 7383 5100 Mobile: 07415 939 401 Email: mark.d.kinsella@uk.gt.com or counter.fraud@nhs.net Alternatively, you can contact the confidential NHS Fraud and Corruption Reporting line (Powered by Crimestoppers) on 0800 028 40 60 or via www.reportnhsfraud.nhs.uk

DO'S AND DON'TS

DO	X DON'T
DO report fraud concerns to your LCFS	X DON'T be afraid to contact the LCFS for advice
DO report your concerns promptly	X DON'T confront an individual with your suspicions
DO keep any documentary evidence / notes	X DON'T investigate the matter yourself
DO remember that fraud and corruption can make victims of us all	X DON'T ignore it or do nothing!

All reported fraud will be investigated by the LCFS and, if appropriate, the police or other agencies may be involved.

Appendix 2

Fraud and Corruption Policy Guidance on Business Conduct – Checklist for staff

Do:

- Make sure you understand the guidelines on standards of business conduct, and consult your line manager if you are not sure.
- Make sure you are not in a position where your private interests and NHS duties may conflict.
- Ensure that the LAS is aware of all other employment that you may undertake.
- Declare to your employer any relevant interests. If in doubt, ask yourself:
    a. am I, or might I be, in a position where I, (or my family/friends) could gain from the connection between my private interests and my employment?
    b. do I have access to information which could influence purchasing decisions?
    c. could my outside interest be in any way detrimental to the NHS or to patients' interests?
    d. do I have any other reasons to think I may be risking a conflict of interest?

If still unsure - **Declare it!**

- Adhere to the ethical code of the Institute of Purchasing and Supply if you are involved in any way with the acquisition of goods and services.
- Seek your employer's permission before taking on outside work, if there is any question of it adversely affecting your NHS duties.
- Obtain your employer's permission before accepting any commercial sponsorship.

Do not:

- Accept any personal gifts, inducements or any hospitality which has a monetary value of £25 or above without consulting with your line manager – refer to Standing Orders on *The Pulse*.
- Abuse your past or present official position to obtain preferential rates for private deals.
- Unfairly advantage one competitor over another or show favouritism in awarding contracts.
- Misuse or make available official "commercial in confidence" information.

This checklist is extracted from HSG (93)5 Standards of Business Conduct for Staff (within this HSG, the Bribery Act 2010 replaces the 'Prevention of Corruption Acts '1889 - 1916'), and can be found at Appendix 4 to this document but if you have any queries please raise these with the Company Secretary, the Chief Finance Officer or your Local Counter Fraud Specialist.

Guidance for Declaring Other Employment

All staff are required to consult with their line manager regarding other employment if they are considering taking on outside work or are already employed elsewhere. All such notifications and discussions will be kept confidential. The grievance procedure or preliminary interview with People and Culture is an option if you are unhappy with your manager's decision.

It may be appropriate to address the following questions in discussions with your manager:

1. Is there likely to be a "business" conflict of interests, e.g. working for a local organisation with which LAS has dealings?

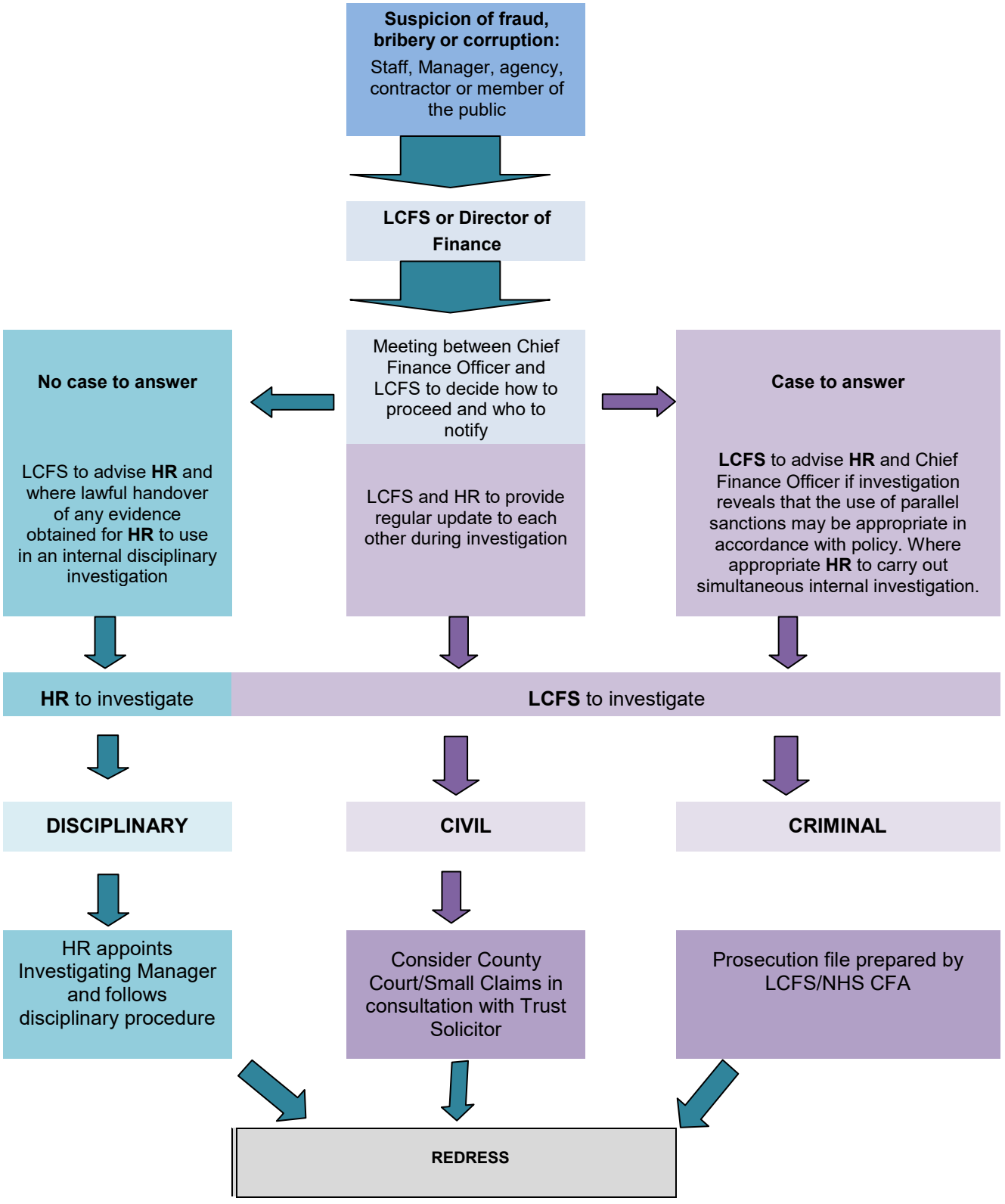
2. Is it possible that your secondary employment will interfere with your capacity to complete to your satisfaction, or your manager's, your duties or responsibilities at LAS?

3. Will you, in the course of your secondary employment, use LAS's equipment, stationery, lease cars or any other of LAS's resources?

4. Will your secondary employment in any way be detrimental to LAS's interests?

Appendix 3

Fraud, Bribery and Corruption Reporting Process



Appendix 4

Fraud, Bribery and Corruption Referral Form

REPORT FRAUD TO THE LOCAL COUNTER FRAUD SPECIALIST

(Please use a separate referral form for each individual / company reported)

Please complete this form to the best of your knowledge. The information you provide will enable the Local Counter Fraud Specialist to evaluate the allegation to determine if this relates to NHS fraud/bribery/corruption and commence initial enquiries. Where you are not able to complete any part of this form, please insert 'not known'.

Mark Kinsella
Landline: 020 7383 5100
Mobile: 07415 939 401
Email: mark.d.kinsella@uk.gt.com or counter.fraud@nhs.net

Any information provided will be treated in the strictest confidence.

SECTION A			
To whom does the alleged fraud relate to? Please delete as appropriate?			
Patient Please complete Section B, C Part 1 & 3	Yes / No	**Trust Staff or Trust GP Practice staff** Please complete Section B and C (in Full)	Yes / No Please state which.
Member of the Public Please complete Section B, C Part 1 & 3	Yes / No	**Company or Supplier** Please complete Section B, C and D	Yes / No

SECTION B	
Reporting Person (s) Contact Details (We can then get in touch with you to discuss your concerns)	
Name	
Organisation and Department	
Site address:	
How can we get in touch with you?	(Please do provide a telephone number and email address)

SECTION C	
Person the alleged fraud relates to ***Please complete as much information as known.***	
PART 1	
Name	
Address	
Date of birth	
Telephone number and e-mail address	
Period of fraud. Is the fraud still occurring?	
PART 2	
For Trust staff or GP Practice staff, please complete:	
Where they work?	**(Organisation, Department and Site)**
Job role	
Full time / Part time	**(including hours and shifts if known, and if relevant to allegation)**
PART 3	
Please provide information and concerns of fraud	
Suspicion / allegation	
Estimated value of fraud	
Are there any witnesses or people who can provide additional details?	**(Please give names and contact details and any relevant information)**
Is there any evidence you have or are aware of that you believe can support the allegation?	**(Please provide details)**

SECTION D	
Company the alleged fraud relates to ***Please complete as much information as known***	
PART 1	
Company name	
Company number and registered address	
Services supplied by company to the Trust	
Trust Site address services/works supplied at:	
Company telephone number and e-mail address	
Director name	**(Please also complete Section C, Part 1)**
Members or persons working for the company related to the allegation	**(Please also complete Section C, Part 1)**

PART 2	
Please provide information of concerns of fraud	
Suspicion / allegation	
Are there any witnesses or people who can provide additional details?	**(Please give names and contact details and any relevant information)**
Is there any evidence you have, or you believe can support the allegation?	**(Please provide details)**

Please send/attach any available information that supports your suspicion.

Signed……..……
Date…….

The Local Counter Fraud Specialist will undertake to acknowledge receipt of this referral direct to you within 2 working days unless otherwise requested.

Appendix 5

STANDARDS OF BUSINESS CONDUCT FOR LONDON AMBULANCE SERVICE NHS TRUST

1. INTRODUCTION

1.1. These guidelines are produced in the light of the challenges that staff face in the new and more commercially oriented environment of Trust status, and are intended by the Trust to reinforce the guiding principles set out in the Codes of Conduct and Accountability in the NHS published by the Appointments Commission April 2004 for NHS Boards. Should there by any conflict between these principles and EL(94) 40 the latter will take precedence.

1.2. In promoting and safeguarding the reputation and standing of the London Ambulance Service NHS Trust (the Trust) with local communities, with customers and suppliers, with patients and with the media, it is Trust policy that the professional and social conduct of staff should reflect the highest possible standard of personal integrity and that the business affairs of the Trust are conducted in a moral, honest manner and in full compliance with all the applicable laws and Trust Standing Orders.

2. RESPONSIBILITY OF THE TRUST BOARD

2.1. The Trust Board is responsible for bringing these guidelines to the attention of all LAS staff and for introducing procedures to ensure that they are implemented.

3. RESPONSIBILITY OF LAS DIRECTORS

3.1. All LAS Directors have a responsibility to uphold these guidelines and to act primarily at all times, in the interest of the Trust as a whole.

4. RESPONSIBILITY OF LAS STAFF

4.1. It is the responsibility of Trust staff to ensure that they do not place themselves in a position where their private interests and the Trust duties conflict. This primary responsibility applies to all Trust staff.

5. GUIDING PRINCIPLE IN CONDUCT OF PUBLIC BUSINESS

5.1. It is important that the Trust, along with all public sector bodies, must be seen to be impartial and honest in the conduct of its business and that its staff should remain above suspicion. It is an offence under the Bribery Act 2010 for a member of staff corruptly to accept any inducement or reward for doing, or refraining from doing, anything in his or her official capacity, or corruptly showing favour, or disfavour, in the handling of contracts.

5.2. Note: Staff should be aware that a breach of the provisions of the Bribery Act 2010 renders them liable to prosecution and may lead to loss of their employment and superannuation rights in the Trust. Failure to adhere to the Business Conduct Policy may result in disciplinary action if it is proved that the employee has failed to declare a relevant interest, or has abused his/her official position or knowledge, for the purpose of self-benefit or the benefit of family, friends or those others with whom the employee has a relationship as defined in paragraph 33.3 of these Standing Orders.

6. PRINCIPLES OF CONDUCT WITHIN THE TRUST

6.1. Trust staff are expected to give the highest possible standard of service to the public and to provide appropriate advice to Directors of the Trust and to fellow employees. In particular Trust staff are required to:

6.1.1 ensure that the interests of patients remain paramount at all times;

6.1.2 be impartial and honest in their conduct of official business; and

6.1.3 use the public monies entrusted to them in a responsible and lawful manner to the best of advantage of the Trust, always ensuring value for money and avoiding legal challenge to the authority.

6.1.4 It is also the responsibility of Trust staff to ensure that they do not:

- abuse their official position for personal gain or to benefit their family or friends; and
- seek to advantage or further their private business or other interests in the course of their official duties.

6.2 Wherever Trust staff have private or personal interests in any matter they have to deal with at work, they must not let these interests influence how they act on behalf of the Trust. Interest may be financial interests but non-financial interest can be just as important. Kinship; friendship; membership of an association, society or trusteeship and any other kinds of relationships can sometimes influence the judgement of Directors and employees of the Trust, or may be thought to do so. A good test is for staff to ask themselves whether others could possibly think the interest be close enough or of such a nature as to give rise to any suspicion. In such cases the member of staff must disclose the interest to the Chief Executive through his or her Director.

7. DECLARATION OF INTEREST

7.1. The Trust Board must be advised of all cases where a member of staff or his/her close relative, partner or associate has a controlling, or significant, or financial interest in a business, or any other activity, which may compete for a contract to supply goods or services to the Trust.

7.2. All Trust staff are required to declare such interests either when they are appointed or on acquisition of the interest, in order that it may be known to the Trust and in no way promoted to the detriment of the Trust or to the patients served by the Trust.

7.3. A Register of Interests shall be maintained by the Trust Secretary to whom all declarations must be submitted in writing. This Register shall be made available for inspection by all Trust Directors, by the public, and by contractors.

7.4. In determining what needs to be declared all Trust staff should:

7.4.1. ensure that they understand these guidelines and consult their line managers if further clarification is required;

7.4.2. ensure that they are not in a position where their private interest and their Trust duties conflict;

7.4.3. declare to the Trust Board any relevant interests; if in doubt they should ask themselves:

7.4.4. am I, or might I be, in a position where I or my family or associates might gain from the connection between my private interests and my employment with the Trust?

7.4.5. do I have access to information which could influence purchasing decisions?

7.4.6. could my outside interest be in any way detrimental to the Trust or to patients' interests?

7.4.7. do I have any reason to think that I may be risking a conflict of interest?

7.5. If still unsure - **declare it!**

8. PREFERENTIAL TREATMENT IN PRIVATE TRANSACTIONS

8.1. Individual staff must not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of the Trust. (This does not apply to any arrangements negotiated with companies on behalf of the Trust, or by recognised staff organisations, on behalf of all staff - for example LAS staff benefit schemes).

9. OTHER EMPLOYMENT

9.1. It is a condition of employment that Trust staff do not undertake any other employment, paid or unpaid, which conflicts with the requirements of their Trust post or be detrimental to it. Staff wishing to take up any employment must provide full details and seek prior written authority from the Director of People and Culture. The Trust will be responsible for judging whether the interests of patients or of the Trust could be harmed e.g.:

9.1.1. full-time ambulance staff who undertake driving duties outside their employment;

9.1.2. employees associated with or working for private transport organisations; or

9.1.3. employees undertaking alternative employment.

9.2. If written approval is given to a member of staff to undertake any other employment the Director of People and Culture will ensure that this is recorded in the Register of Staff Engaged on Other Employment held in his/her department.

10. ACCEPTANCE OF GIFTS AND HOSPITALITY

10.1. All gifts, payments or any other contribution made whether in cash or in kind, shall be documented, regularly reviewed, and properly accounted for on the books of the Trust. Courtesy gifts and hospitality must not be given or received in return for services provided or to obtain or retain business but shall be handled openly and unconditionally as a gesture of esteem and goodwill only. Gifts and hospitality shall always be of symbolic value, appropriate and proportionate in the circumstances, and consistent with local customs and practices. They shall not be made in cash. Please refer to the LAS Gifts and Hospitality Policy for more information.

10.2. National Health Service regulations prohibit staff from soliciting gifts or hospitality from organisations, suppliers or individuals with whom they are brought into contact in the course of their work.

10.3. As a general rule all offers of gifts and hospitality should be refused except where such a refusal would cause offence but acceptance must be limited to items similar to those set out below:

10.4. Casual gifts offered by contractors and others, for example:

10.3.1 at Christmas time (articles of low intrinsic value (up to £25) such as pens, calendars, diaries etc.) or

10.3.2 small items of low value (up to £25) such as desk furniture and tankards received at the conclusion of an official visit or conference or seminar. These items may not be connected with the performance of duties so as to constitute an offence under the Bribery Act 2010. Items of this nature do not need to be declared.

10.3.3 Staff must not, however, accept any money gifts or consideration where such acceptance could be deemed to influence or to have influenced their business conduct. Any member of staff who is unsure whether or not to accept a gift must consult their line manager or the appropriate Director. The Chief Executive will consult the Chairman in respect of gifts offered to him.

10.3.4 Tokens of gratitude from patients or their relatives must be politely but firmly declined. If, however, patients insist on crews accepting such gratuities, these must be reported to their line manager who will make arrangements for charity allocation.

10.3.5 Registers of Gifts Offered and Accepted shall be maintained by the Trust Secretary and all details of gifts offered and accepted must be submitted to him/her on a monthly basis. This will be reported to the Audit Committee.

10.3.6 Employees should only accept offers of hospitality if there is a genuine need to impart information or represent the Trust and that the Trust will benefit from such hospitality.

10.3.7 Modest hospitality may be accepted provided that it is normal and reasonable in the circumstances, for example, lunches in the course of working visits. In accepting hospitality, however, staff must not place themselves in a position where acceptance might be deemed by others to have influenced them in making a business decision. Offers to attend purely social or sporting functions should be accepted only when these are part of the life of the community served by the Trust or it is in the Trust's interest to attend for the execution of its business or its operational activity or where the Trust should be seen to be represented. Attendance at such events must be approved in advance by the relevant Director or by the Chief Executive for Directors and by the Chairman for such requests made by the Chief Executive. They should be properly authorised and then recorded by the Trust Secretary.

10.3.8 The frequency and type of hospitality accepted must not be significantly greater than the Trust would be likely to provide in return.

10.3.9 Offers of hospitality involving the provision of transport or overnight accommodation must only be accepted after approval from the appropriate Director or Chief Executive. If in doubt about the acceptance of hospitality, staff must seek advice from their line manager or appropriate Director, or in the case of the Chief Executive, the Chairman.

10.3.10 Registers of Hospitality Offered and Accepted shall be maintained by the Trust Secretary.

10.3.11 On an annual basis the Trust Secretary will remind all staff of the Trust's policy regarding the acceptance of gifts and hospitality.

11. COMMERCIAL SPONSORSHIP OR ATTENDANCE AT COURSES AND CONFERENCES

11.1 Acceptance by employees of hospitality through attendance at relevant conferences and courses is acceptable, but only where it is clear that the hospitality is corporate rather than personal and where the employee seeks permission in advance and the Trust is satisfied that acceptance will not compromise purchasing decisions in any way. On occasions where it is considered necessary for staff advising on the purchase of equipment in operation in other parts of the country, or, exceptionally, overseas, to attend courses and conferences the Trust may consider meeting the costs so as to avoid jeopardising the integrity of subsequent purchasing decisions.

12. COMMERCIAL SPONSORSHIP OF POSTS - LINKED DEALS

12.1 If a company offers to sponsor a post for the Trust either wholly or partially, it should be made clear that the sponsorship can have no effect on purchasing decisions within the Trust. Where such sponsorship is accepted, purchasing decisions must be monitored by the Company Secretary to ensure that they are not being influenced by the sponsorship arrangement.

12.2 Under no circumstances should the Trust agree to Linked Deals whereby sponsorship is linked to the purchase of particular products or to supply from a particular source.

13. "COMMERCIAL IN-CONFIDENCE"

13.1 Staff must not make public internal information of a "commercial in-confidence" nature, particularly if its disclosure would prejudice the principle of a purchasing system based on fair competition. This principle applies whether private competitors or other NHS providers are concerned, and whether or not disclosure is prompted by the expectation of personal gain. The term "commercial in-confidence" should not be taken to include information about service delivery and activity levels, which should be publicly available. Nor should it inhibit, for example, the exchange of data for medical purposes subject to the normal rules governing patient confidentiality and data protection. In all circumstances the overriding consideration must be the best interest of patients.

14. COMPLAINTS ABOUT BREACHES OF THE CODE

14.1 Any staff complaints about breaches of the guidelines on Standards of Business Conduct, maladministration or other concerns of an ethical nature should be taken up initially, through line management. Should that be inappropriate or non-productive then the matter should be referred up to Director and, if necessary, to Board level. Any report or suspicion of fraud or bribery will be referred by the Chief Finance Officer to the LCFS for further investigation, or in cases where the Chief Finance Officer is alleged to be involved a report will be made direct from the delegated responsible board member. Please refer to the Fraud Act 2006 and Bribery Act 2010.

London Ambulance Service NHS Trust

Nomination and Remuneration Committee
Terms of Reference (effective January 2020-March 2021)

1. Purpose

1.1 The Nomination and Remuneration Committee has been established in order to oversee the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board and to establish and monitor the reward levels and structures for the Trust's Executive Directors and Very Senior Managers, ensuring transparency, fairness and consistency.

2. Constitution

2.1 The Committee is a standing committee of the Trust's Board of Directors. These terms of reference are subject to amendment at future meetings of the Trust Board.

3. Authority

3.1 The Committee is authorised by the Trust Board to act within its terms of reference. All members of staff are directed to cooperate with any request made by the Committee.

3.2 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

3.3 The Committee is authorised by the Trust Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the conduct of its functions.

4. Accountability

4.1 The Committee will report directly to the Trust Board.

5. Membership

5.1 The Committee shall be appointed by the Board and shall consist of all the Non-Executive Directors, all of whom shall have voting rights.

6. Chair

6.1 The Trust Chairman shall be the Chair of the Committee.

7. Attendance

7.1 The Trust Chief Executive should normally attend all Nomination and Remuneration Committee meetings, with the exception of discussions about their own remuneration and terms of service.

7.2 The Director of Corporate Governance and the Director of People and Culture should normally attend all Nomination and Remuneration Committee meetings, with the exception of discussions about their own remuneration and terms of service.

7.3 Other Executive Directors and officers may be invited to attend to discuss matters as directed by the Committee.

8. Quorum

8.1 The meeting will be quorate provided that the following are in attendance;

8.1.1 The Trust Chairman (unless there are exceptional circumstances which mean that the Chair cannot be in attendance, in which case either a specifically nominated deputy, or the Deputy Chair shall be in the chair); and

8.1.2 Three Non-Executive Directors.

9. Meeting administration

9.1 The Director of Corporate Governance or their nominee will act as the secretary to the Committee, ensuring the agreement of the agenda with the Chair of the Committee and attendees, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward.

9.2 The draft minutes and action points will be available to the Committee within five working days of the meeting.

10. Notice of meetings

10.1 Meetings of the Committee shall be called by the secretary of the Committee at the request of the Committee chair.

10.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be circulated to each member of the Committee, any other person required to attend and all other Non-Executive Directors, no later than seven calendar days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

10.3 Late and additional papers will be tabled at the discretion of the Chair of the Committee.

11. Frequency of meetings

11.1 Meetings will be held at least twice a year with ad hoc meetings held at the request of the Chair or any three members of the Committee. The regularity of meetings will be reviewed annually. A calendar of dates will be published with the agenda setting out the dates of the meetings for the remainder of the financial year.

12. Duties

Nomination/Appointments

12.1 To work with the Board regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the Board evaluation process as appropriate, and make recommendations to the Board with regard to any changes.

12.2 To give full consideration to succession planning for all Executive and Non-Executive Board members, taking into account the challenges, risks and opportunities facing the Trust and the skills and expertise needed on the Board in the future.

12.3 To keep the leadership needs of the Trust under review at executive level to ensure the continued ability of the Trust to operate effectively and to have an input into the recruitment of or continuation of any Very Senior Manager (VSM) role.

12.4 When a Non-Executive or Executive Director vacancy is identified (and at least annually otherwise), to evaluate the balance of skills, knowledge and experience on the Board, and its diversity, and in the light of this evaluation endorse a description of the role and capabilities for the particular appointment.

12.5 To ensure that Non-Executive or Executive Directors meet the requirements of the Trust's Fit and Proper Person Policy on appointment (and at least annually otherwise).

12.6 To endorse the appointment of Executive Directors, taking into account the advice of the Chief Executive. The Committee shall not endorse an appointment to an Executive Director position which the Chief Executive does not support; rather a further recruitment process shall commence for the role in question.

12.7 To consider any matter relating to the continuation in office of any Executive Director (including the Chief Executive), including the suspension or termination of service of an individual as an employee of the Trust to the provisions of their law and their service contract.

Remuneration

12.8 To establish and keep under review a remuneration policy in respect of Executive Directors and Very Senior Managers (VSMs) on locally determined pay (i.e. not Agenda for Change pay scales).

12.9 Agree the policy for authorising claims for expenses from the Trust Chairman, Non-Executive Directors and Executive Directors.

12.10 To obtain reliable and up-to-date information about remuneration in other Trusts and comparable organisations.

12.11 If independent remuneration consultants are used to advise the Committee, to establish the selection criteria, select, appoint and set the terms of reference for their use. Where remuneration consultants are appointed, a statement shall be made available of whether they have any other connection with the Trust.

12.12 (In consultation with the Chief Executive), to agree and monitor the level and structure of remuneration for the Trust's Executive Directors and VSMs.

12.13 (In consultation with the Chief Executive (other than when considering their own remuneration package)), to determine the total individual remuneration package of each Executive Director. In doing so the Committee shall:

12.13.1 Ensure that the levels of remuneration are sufficient to attract, retain and motivate Executive Directors of the quality required to run the Trust successfully. They shall, however, avoid paying more than is necessary for the purpose;

12.13.2 Judge where to position the Trust relative to other NHS Trusts, NHS foundation trusts and comparable organisations. Such comparisons, however, shall be used in caution in view of the risk of an upward ratchet of remuneration levels with no corresponding improvement in performance;

12.13.3 Be sensitive to pay and employment conditions elsewhere in the Trust, especially when determining annual salary increases;

12.13.4 Ensure that neither the Chief Executive nor any other Executive Director is involved in deciding his or her own employment arrangements, including their own remuneration; and

12.13.5 Ensure that where Executive Directors or senior management are involved in advising or supporting the Committee, care is taken to recognise and avoid conflicts of interest.

12.13.6 Ensure that, in considering recommendations for remuneration packages, the Committee has:

12.13.6.1 A clear statement of the responsibilities of the individual post and its accountability for meeting objectives of the organisation;

12.13.6.2 Means of assessing the comparative size of the individual post by job evaluation and benchmarking;

12.13.6.3 Comparative salary information from the NHS, other public sector organisations including Trusts, and other industrial and service organisations;

12.13.6.4 Consistently applied the Trust's remuneration policy.

12.14 (In consultation with the Chief Executive (other than when considering their own remuneration package)), to determine the award of any performance related pay in line with the requirements of the VSM Pay Framework.

Other

12.15 To receive any other relevant items as identified by the Chair of the Committee.

13. Review and reporting responsibilities

13.1 The minutes of all meetings of the Committee shall be formally recorded and submitted to the Trust Board.

13.2 The Committee will report to the Trust Board after each meeting via an assurance report, which will provide an overview of the discussions at the meeting, details of any matters in respect of which actions or improvements are needed and decisions taken.

13.3 The Committee will report annually to the Trust Board in respect of the fulfilment of its functions in connection with these terms of reference (ensuring that all provisions regarding disclosure of remuneration, including pensions, are fulfilled, which shall form part of the Trust's annual report). This will include an evaluation of its performance according to a standardised framework and process.

13.4 All terms of reference will be reviewed annually with any changes submitted to the Trust Board for approval

14. Equality and diversity

14.1 The committee will have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

TO BE Approved by the Board at its meeting on 28 January 2020

London Ambulance Service NHS Trust

Charitable Funds Committee

Terms of Reference (effective January 2020 – March 2021)

1. Purpose

1.1 The Charitable Funds Committee has been established in order to make and monitor arrangements for the control and management of the London Ambulance Service NHS Trust Charity's funds and to effect the delegation of day-to-day responsibility to ensure that the Charity's funds are exercised within appropriate controls and governance.

1.2 The Committee will oversee, on behalf of the Trustees of the London Ambulance Service NHS Trust Charity[1], the management, investment and disbursement of charitable funds within the regulations provided by the Charities Commission and to ensure compliance with the laws governing charitable funds.

2. Constitution

2.1 The Committee is a standing committee of the Trust's Board of Directors. These terms of reference are subject to amendment at future meetings of the Trust Board.

3. Authority

3.1 The Committee is authorised by the Trust Board to act within its terms of reference. All members of staff are directed to cooperate with any request made by the Committee.

3.2 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

3.3 The Committee is authorised by the Trust Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the conduct of its functions.

[1] The London Ambulance Service NHS Trust (LAS) Board members shall act as the Trustees of the London Ambulance Services NHS Trust Charity. The Trustees shall hold the Trust Funds upon trust to apply for any charitable purpose or purposes relating to the NHS wholly or mainly for the services provided by the LAS.

4. Accountability

4.1 The Committee will report directly to the Trust Board.

5. Membership

5.1 The Committee shall be appointed by the Board from amongst the Non-Executive Directors and Executive Committee of the Trust (including the Chief Finance Officer and the Director of Communication and Engagement) and shall consist of not less than four members, all of whom shall have voting rights.

6. Chair

6.1 One Non-Executive Director member will be the Chair of the Committee and, in their absence, another Non-Executive Director member will be nominated by the others to deputise for the Chair.

7. Attendance

7.1 The Trust Secretary, Financial Controller, Head of First Responders and at least one nominated staff side representative (identified by the Staff Council) should normally attend all Charitable Funds Committee meetings.

7.2 Other Executive Committee members and officers may be invited to attend to discuss matters as directed by the Committee.

8. Quorum

8.1 The meeting will be quorate provided that the following are in attendance;

8.1.1 The Chair or nominated Chair of the Committee; and
8.1.2 At least one of the two Executive Committee members, one of whom must be the Chief Finance Officer or Director of Communication and Engagement, or their nominated representative.

9. Meeting administration

9.1 A member of the Corporate Governance Team will act as the secretary to the Committee, ensuring the agreement of the agenda with the Chair of the Committee and attendees, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward.

9.2 The draft minutes and action points will be available to the Committee within five working days of the meeting.

10. Notice of meetings

10.1 Meetings of the Committee shall be called by the secretary of the Committee at the request of the Committee chair.

10.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be circulated to each member of the Committee, any other person required to attend and all other Non-Executive Directors, no later than seven calendar days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

10.3 Late and additional papers will be tabled at the discretion of the Chair of the Committee.

11. Frequency of meetings

11.1 Meetings will be held in October and March with additional meetings held on an exceptional basis at the request of the Chair or any three members of the Committee. The regularity of meetings will be reviewed annually. A calendar of dates will be published with the agenda setting out the dates of the meetings for the remainder of the financial year.

12. Responsibility

12.1 To act on behalf of the Trust in satisfying the duties and responsibilities of trustees in managing the funds;

12.2 To ensure that policies and procedures are in place to meet the requirements of the Charities Commission and the laws governing charitable funds;

12.3 To establish an investment strategy in accordance with the Trustee Act 2000 and if necessary to appoint fund managers to act on its behalf;

12.4 To monitor the performance of investments and of appointed Investment Managers;

12.5 To review the charity's reserves policy;

12.6 To review the income and expenditure transactions for all funds;

12.7 To review legacies received and ensure that the Trust complies with the terms of the legacy;

12.8 To examine the financial statements of the charity and approve the annual return and the annual accounts in line with the requirements of the Charities Commission and the laws governing charitable funds;

12.9 To approve the charitable funds annual budget; and

12.10 To authorise the establishment of new funds and new charities.

13. Review and reporting

13.1 The minutes of all meetings of the Committee shall be formally recorded and submitted to the Trust Board.

13.2 The Committee will report to the Trust Board after each meeting via an assurance report, which will provide an overview of the discussions at the meeting, details of any matters in respect of which actions or improvements are needed and decisions taken.

13.3 The Committee will report annually to the Trust Board in respect of the fulfilment of its functions in connection with these terms of reference. This will include an evaluation of its performance according to a standardised framework and process.

13.4 All terms of reference will be reviewed annually with any changes submitted to the Trust Board for approval

14. Equality and diversity

14.1 The committee will have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

TO BE Approved by the Board at its meeting on 28 January 2020

London Ambulance Service Staff Advisory Panel – Initial Terms of Reference (effective January 2020-March 2020)

1. Purpose

1.1 The London Ambulance Service Staff Advisory Panel (the Panel) will bring together a range of staff from across the Trust at regular intervals to provide feedback to the Board informed by the experience of staff members. It is intended to enhance, rather than replace, current staff engagement activities and working arrangements with trades unions.

1.2 The Panel's membership will bring broad staff insight and experience to discussions, helping to shape the way in which the organisation operates. They will cover a number of broad areas of activity including:

1.2.1 Individual care and treatment
1.2.2 Service delivery, design and transformation
1.2.3 Strategy and forward planning

1.3 The purpose of the Panel is to:

1.3.1 Provide a voice for staff to advise the Board's consideration of the design, development and delivery of Trust services
1.3.2 Advise the Board on ways to gain broader staff engagement, as necessary.

1.4 The Panel will have an agreed programme of work to allow for other engagement activity to be conducted in advance of meetings to help bring wider insight to the membership as appropriate. The Panel is not itself responsible for implementation and nor does it cut across the current statutory accountabilities of the London Ambulance Service NHS Trust.

2. Constitution

2.1 The Panel is an advisory committee of the Trust's Board of Directors. These terms of reference are subject to amendment at future meetings of the Trust Board.

3. Accountability

3.1 The Panel will report directly to the Trust Board.

4. Membership

4.1 The Panel will have a membership of around x people and should ensure a diversity of age, gender, background and experience of working within the London Ambulance Service.

4.2 Members are appointed on an individual (not ex-officio) basis but will be drawn from a range of teams across the organisation to ensure a plurality of experience.

4.3 It is anticipated that membership of the Panel will be on a rotational basis, for a period of 2-3 years. The membership of the Panel will be drawn from the Trust's Staff Survey Champions and special focus staff networks.

5. Chair

5.1 The Panel will be led by the Chair of the Trust, together with a Co-Chair drawn from the membership of the Panel.

5.2 The Chair of the Trust and the Co-Chair will have a role both at and between meetings in setting the Panel's agenda and ensuring that the Panel is influential and impactful.

5.3 The Co-Chair of the Panel will be expected to attend all public meetings of the Trust Board.

6. Attendance

6.1 Officers from the London Ambulance Service NHS Trust and other health and social care system partners will participate in all sessions of the Panel in attendance (in limited number).

6.2 Experts may be invited to meetings or sessions of meetings on an ad-hoc basis to provide opinion, information and evidence on specific matters.

7. Quorum

7.1 The meeting will be quorate provided that the following are in attendance;

7.1.1 The Co-Chairs of the Panel or a nominated Deputy; and
7.1.2 At least one-third of the total membership of the Panel.

8. Meeting administration

8.1 A member of the Corporate Governance Team will act as the secretary to the Panel, ensuring the agreement of the agenda with the Co-Chairs of the Panel and attendees, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward.

8.2 The draft minutes and action points will be available to the Panel within ten working days of the meeting.

9. Notice of meetings

9.1 Meetings of the Panel shall be called by the secretary of the Panel at the request of the Co-Chairs.

9.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be circulated to each member of the Panel, any other person required to attend, no later than seven calendar days before the date of the meeting. Supporting papers shall be sent to Panel members and to other attendees as appropriate, at the same time.

9.3 Late and additional papers will be tabled at the discretion of the Co-Chairs of the Panel.

10. Frequency of meetings

10.1 Meetings of the full Panel will be typically held four times per annum.

11. Duties

11.1 TO BE DEVELOPED WITH THE PANEL.

12. Review and reporting responsibilities

12.1 The minutes of all meetings of the Panel shall be formally recorded and submitted to the Trust Board.

12.2 The Co-Chair of the panel shall attend public meetings of the Trust Board in order to report on the work of the Panel after each meeting.

12.3 The Panel will report annually to the Trust Board in respect of the fulfilment of its functions in connection with these terms of reference. This will include an evaluation of its performance according to a standardised framework and process.

12.4 All terms of reference will be reviewed annually with any changes submitted to the Trust Board for approval

13. Equality and diversity

13.1 The Panel will have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

TO BE Approved by the Board at its meeting on 28 January 2020

ANNEX

Principles of membership

Members must at all times:

- Observe the values and respective behaviours of the London Ambulance Service – respectful, professional, innovative and collaborative
- Observe the highest standards of impartiality, integrity and objectivity in relation to the advice they provide
- Be accountable for their activities
- Not misuse information gained in the course of their membership of the Panel for personal gain or for political purpose, nor seek to use the opportunity of public service to promote their private interests or those of connected persons, firms, businesses or other organisations
- Not hold any paid or high-profile posts in a political party, and not engage in specific political activities on matters directly affecting the work of the Panel. When engaging in other political activities, members should be conscious of their public role and exercise proper discretion.

Declarations of interest

Upon appointment all members of the Panel will be formally required to complete a Declaration of Interest Form and a Register of Members Interests will be established and updated on an annual basis. It is the responsibility of members to declare any new interests as and when they arise and to ensure that the Register of Members Interests is kept up to date.

The Chair will be responsible for managing declarations of interest and any conflicts of interest within the meeting and determine on what basis a member declaring a relevant interest can participate in discussion.

London Ambulance Service NHS Trust
Register of Interests of Decision-Making Staff

Period: 01 October 2019 - 31 December 2019

Date of Publication: January Board meeting

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Alan Taylor	Head of Safeguarding	Ad Hoc work for CQC	N/A		I take occasional annual leave and work for the CQC as a Specialist Advisor
Ali Layne-Smith	Director - People & Culture	**Non-financial professional interest:** Attended dinner with other London based NHS HRDs hosted by Bevan Brittan LLP	12/11/2019	12/11/2019	Bevan Brittan provide employment law services to several NHS Trusts. Dinner and drinks in excess of £25
Ali Layne-Smith	Director - People & Culture	**Non-financial personal interest:** Attended lunch with Kate Ludlow and Hatty Cadman of Saxam Bamflyde	20/11/2019	20/11/2019	Saxam Bamflyde are an Executive Search firm and placed me at LAS. They are currently undertaking other Exec Search roles for the Trust. Lunch was in excess of £25.00
Ali Layne-Smith	Director - People & Culture	**Indirect Interest:** Introduced Grahame Russell and Change Associates to Benita Mehra as a potential Change Management contractual supplier	15/10/2019	Present	I have been a customer of Change Associates in 2 previous organisations and for a short period of time in 2016 was listed as one of their Associates. I was placed in my previous role by Change Associates.

London Ambulance Service NHS Trust
Register of Interests of Decision-Making Staff

Ali Layne-Smith	Director - People & Culture	Non financial personal interest	01/10/2019	Date	Trustee of Oasis Community Learning Board. This is an Multi-Academy Trust (MAT) covering 52 schools across the UK
Amit Khutti	Board Director for Zava Global BV	Shareholder in this online doctor service. No current actual conflict of interests, but the company has recently started exploring opportunities to partner with the NHS, which could in theory lead to interaction with LAS. Current discussions are more about interacting with NHS in primary care, rather than ambulance or emergency care, but future roadmap not yet set out	01/12/2018	Current	
Antony Tiernan	Director of Communications and Engagement	I am due to attend the HSJ Awards 2019 ceremony and dinner - cost £495 + VAT	06/11/2019	06/11/2019	I was a judge for the HSJ Awards 2019 and I am on the HSJ Awards Board. As such, I am invited to attend the awards
Antony Tiernan	Director of Communications and Engagement	Engagement and Communications Development Programme Advisory Board	01/04/2017	Ongoing	Unpaid - non-financial professional interest
Antony Tiernan	Director of Communications & Engagement	Pret vouchers from the Awesome Movement totalling £100	20/09/2019	20/09/2019	Donation of vouchers to be shared with staff

London Ambulance Service NHS Trust
Register of Interests of Decision-Making Staff

Antony Tiernan	Director of Communications & Engagement	Pret vouchers from the Awesome Movement totalling £250	23/10/2019	23/10/2019	Donation of vouchers to be shared with staff
Athar Khan	Director of Integrated Patient Care	Trustee, Leo Academcy Trust	01/03/2019	Present	
Brian Jordan	Head of Operational Compliance and Standards	**NIL**			
Fenella Wrigley	Medical Director	Royal London Hospital, Barts Health Emergency Medicine Consultant Financial - Substantive NHS consultant,	01/07/2008	Present	
		St John Ambulance London Region Regional Professional lead for Doctors Non-Financial - Voluntary role	01/08/2012	Present	Volunteer since 1996
		All England Lawn Tennis Club Chief Medical Officer - Financial	01/09/2018	Present	
		Home Office Immigration Services Clinical Advisor -Financial	01/04/2013	Present	
Fergus Cass	Non Executive Director	Director - Melton Court Parking Limited (company managing parking spaces at block where I live)		Present	
Garrett Emmerson	Chief Executive Officer	Non-Executive Director University Buses Ltd	01/02/2019	Present	
Heather Lawrence	Chair	Non-Executive Director at the Royal Marsden Hospital NHS Trust	01/06/2017	Present	

London Ambulance Service NHS Trust
Register of Interests of Decision-Making Staff

Heather Lawrence	Chair	Deloitte Academy Women on Boards dinner	15/05/2019	Present	Current discussions are more about interacting with NHS in primary care, rather than ambulance or emergency care, but future roadmap not yet set out.
Jayne Mee	Non Executive Director	Calabash Limited - Director	01/08/2015	Present	
		MEI - Trust	Sep-16	31/12/2019	Please note I am stepping down from this Board at end 2019
		St John Ambulance - Trustee	Apr-15	Present	
		University Hospitals Bristol NHS Foundation Trust - Non Executive Director	Jun-19	Present	
John Downard	Head of Integrated Service Delivery	**NIL**			
John Downard	Head of Integrated Service Delivery (IM&T)	I hold the position of Company Secretary for my wife's company Downard Consultancy Ltd registered at 19 New Road, Brighton, BN1 1UF	01/09/2017	Present	
John Jones	Non Executive Director	**NIL**			
Julia Crossey	Category Manager	**NIL**			
Karim Brohi	Non Executive Director	**NIL**			
Kevin Bate	*Deputy Director of Operations*	**NIL**			
Khadir Meer	Chief Operating Officer	Chair of Minik Kardes (Children's Charity)	2011	Present	

London Ambulance Service NHS Trust
Register of Interests of Decision-Making Staff

Lorraine Bewes	Director of Finance and Performance	Non Executive Director - Bovill Ltd (a regulatory risk adviser to the financial services sector)	2016	Present	
		Deputy Chair, HFMA Costing for Value Institute	2016	Present	
Mark Spencer	Non Executive Director	**NIL**			
Nick Young	Head of Procurement Transformation	**NIL**			
Paul Candler	Procurement Category Manager	**NIL**			
Pauline Cranmer	Director of Ambulance Services	**NIL**			
Patricia Bain	Chief Quality Officer	Healthcare Consultant - registered company	10/04/2019	Present	Registered as healthcare consultancy and providing advice to other healthcare providers
Paul Gates	Consultant Paramedic	Hon Secretary and Trustee of British Association for Immediate Care (BASICS)	05/10/2017		
		Chair of Board of Directors of BASICS Education	01/06/12019		
		Chair and Trustee Of BASICS Essex Accident Rescue Service	12/06/2011		
		Lead Examiner for Diploma in Immediate Medical Care, Royal College of Surgeons of Edinburgh	01/01/2019		

London Ambulance Service NHS Trust
Register of Interests of Decision-Making Staff

		External Examiner, Graduate Paramedic Programme, University of Limerick	01/08/2016		
		Honorary Visiting Senior Lecturer Anglia Ruskin University	01/09/2015		
		Regional Professional lead (Paramedics) St John Ambulance (London and South Region)	01/01/2015		
Philippa Harding	Director of Corporate Governance	Director of consultancy company working with healthcare organisations	01/08/2019	Present	
Ross Fullerton	*Director of Strategy, Technology and Development*	One hamper from a company called "B. Different"	*10/12/2019*	10/12/2019	Approx. value £25.00
Ruth Tinson	Assistant Medical Director	**NIL**			
Sheila Doyle	Non Executive Director	Deloitte - Employee	01/01/2016	Present	I am a partner and full time employee at Deloitte
		Telstra - Shares	1999	Present	I hold a small number of shares in Telstra - Australian telecommunications company
Theo de Pencier	Non Executive Director	Arms length consumer watchdog	05/01/2015	29/04/2023	
Tina Ivanov	Deputy Director Clinical Education and Standards	Governor - The Discovery School Kent	01/09/2018	01/09/2022	Volunteer role as parent governor on the Full Governors Board of the local Primary School, in Kent

London Ambulance Service NHS Trust
Register of Interests of Decision-Making Staff

Tim Lightfoot	Deputy Medical Director & Consultant in Intensive Care Medicine	Mid Essex Hospitals NHS Trust Consultant in Intensive Care & Anaesthesia	01/03/2015	Present	Required clinical role as per my LAS contract to maintain professional currency
Tim Lightfoot	Deputy Medical Director & Consultant in Intensive Care Medicine	Brish Army Consultant in Intensive Care & Anaesthesia	Mar-13	Present	Army Reservist
Tina Ivanov	Deputy Director Clinical Education and Standards	Gift: 6 Christmas crackers containing small bottles of wine. Value £30			Unknown source provided gift. No known commercial supplier identified with gift. Could potentially be a colleague or friend using work address to delvier personal gift
Vic Wynn	Head of IM&T Strategy, Security and Architecture / Head of Digital Strategy & Sponsorship	**NIL**			

London Ambulance Service NHS Trust

Report to:	**Trust Board**			
Date of meeting:	28 January 2020			
Report title:	Trust Board Forward Planner			
Agenda item:	16			
Report Author(s):	Philippa Harding, Director of Corporate Governance			
Presented by:	Philippa Harding, Director of Corporate Governance			
History:	This planner is based upon previous years' Board agendas and guidance relating to best practice in the construction of Trust Board agendas			
Status:	☒	**Assurance**	☒	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

This report provides the Board with an updated forward plan for Board meetings until the end of the 2019/20 financial year. It is based upon the business conducted by the Board in previous years and upon best practice in the construction of Board agendas.

This is intended to be a framework document, setting out the minimum business to be conducted at Board meetings during the forward plan period. It will be updated regularly to reflect the business needs of the organisation.

Recommendation(s):

The Board is asked to comment on the proposed forward plan for Board meetings until the end of the 2019/20 financial year.

This report relates to the following Board Assurance Framework (BAF) or other risk:

Failure to ensure that the Board spends its time at meetings appropriately could result in an inability to conduct its business and result in poor governance.

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☒
Financial	☒
Workforce	☒
Governance and Well-led	☒
Reputation	☒
Other	☒

This paper supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

Trust Board forward planner: 2019/20

Area	Lead	Tuesday 28 January 2020	Tuesday 24 March 2020
Standing items	HL	Welcome and apologies	Welcome and apologies
	All	Declarations of Interest	Declarations of Interest
	HL	Minutes of previous meeting	Minutes of previous meeting
	HL	Matters arising & action log	Matters arising & action log
	TB	Patient Story	Staff Story
	HL	Report from the Chair	Report from the Chair
	GE	Report from the CEO	Report from the CEO
Strategy & Planning	LB		Operational Plann Approval
	LB		Business Plan Approval
	FW		
	BM		
	BM		
	FW		
	TB		
	PG		
	PG		
	AF		
Quality, Performance & Assurance	LB	Integrated Quality & Performance Report	Integrated Quality & Performance Report
	PH	Board Assurance Committee Reports	Board Assurance Committee Reports
	PH	BAF & Corporate Risk Register	BAF & Corporate Risk Register
	TB	Serious Incident Management	Serious Incident Management
	TB	SI Thematic Review	
	TB		Quality Accounts & Quality Priorities - biannual report
Annual Reporting	LB, PH		Approach to Annual Report & Accounts
	PH		
	JJ		
	TB		
	TB		
	LB		
	FW		
Governance	PH	Approach to Annual Corporate Governance Review	Annual Corporate Governance Review
	PH		
	PH	Freedom to Speak Up Quarterly Report	
	PW	EPRR Update	
Concluding matters	PH	Trust Board forward planner	Trust Board forward planner
	HL	Questions from members of the public	Questions from members of the public
	HL	Any other business	Any other business
	All	Review of the meeting	Review of the meeting
Additional reports	TB	Quality Report	Quality Report

London Ambulance Service NHS Trust

Report to:	**Trust Board**			
Date of meeting:	28 January 2020			
Document Title:	Quality Report			
Agenda item:	Additional report, circulated for information only			
Report Author(s):	Dr Trisha Bain, Chief Quality Officer			
Presented by:	Dr Trisha Bain, Chief Quality Officer			
History:	N/A			
Status:	☒	**Assurance**	☒	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

The quality report containing December 2019 data is attached

The quality report is a review of all relevant quality Key Performance Indicators (KPIs) and information with regards to the quality improvement agenda across the organisation.

Recommendation(s):

The Trust Board is asked to note the information provided within the report, and provide feedback to the Chief Quality Officer.

Links to Board Assurance Framework (BAF) and key risks:

N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☐
Performance	☐
Financial	☐
Workforce	☐
Governance and Well-led	☐
Reputation	☐
Other	☐
This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☐
Efficiency and sustainability will drive us	☒

NHS
London Ambulance Service
NHS Trust

London Ambulance Service – Integrated Quality Report

Report for discussion at the Trust Board

Analysis based on December 2019 data, unless otherwise stated

Contents Page

London Ambulance Service NHS Trust

Executive Summary

NHS London Ambulance Service NHS Trust

Quality Domain	Highlights from this report by quality domain
Safe	We continue to see good reporting of patient safety incidents in both 999 and IUC Services resulting in 3.7 events per 1000 incidents with increases in no and low harm incidents being reporting, which is positive. This allows the Trust to identify themes and these continue to be dispatch and call, clinical treatment and medical equipment related. The new JRCALC Plus app has been rolled out to ensure frontline crews continue to have up-to-date medicines information, also new PGDs to expand range of APP drugs have been finalised. The total number of H&S incidents was 387 resulting in 3.76 events per 1000 A&E (face to face) incidents the top themes are physical assault, directed verbal abuse, and manual handling (lifting patients) incidents. The timeframe compliance of reporting RIDDOR incidents (<15 days) to the HSE across the Trust during December' 19 is 85% compared to 92% in November' 19. The Flu CQUIN is currently at 49% uptake across the Trust. There is a proactive vaccination programme continuing.
Effective	Our rates of ROSC for cardiac arrest patients were above the national average for both the overall (31.4%) and Utstein (62.5%) groups however our survival to discharge remains below the national average at 7.9% of all patients and 30.2% of patients in the Utstein group. Due to significant pressures in IUC in December fewer than the required audits (50% in NEL) were completed. A programme of work is ongoing to complete retrospective audit. This was a finding in the recent CQC report.
Caring	The End of Life Care (EoLC) pioneer service has seen ED conveyance rate decrease since April 2019 (35%) to 29.1%. To improve staff confidence in skills & knowledge, palliative care training sessions are being run which has seen an 24% increase of post education confidence. The MHJRC has been expanded pan London to support over the winter period. The service will be reviewed and a strategic decision made on the future of this service in the coming months.
Responsive	The number of complaints responded to within 35 working days has surpassed the target of 75% and is currently 77%. This is on track to be maintained throughout the remaining year. The main themes continues to be conduct and behavior and work is underway with AvMA to develop relevant staff training. There were 17 complaints attributed to NHS111 in November and December, 7 related to NELIUC and 10 from SELIUC. Due to recent high demand, delays in call and dispatch has been identified as a patient safety theme and the Chief Medical Officer is maintaining daily oversight of delays to assess any potential harm.
Well led	Learning from SI's, Excellence Reporting, Claims and Inquests are discussed in detail at the Serious Incident Assurance and Learning Group (SIALG) and include medicine, security and IUC improvement actions. There is a need for a continued focus on NEL appraisals as this was 53.08% at the end of December. The Quality Directorate are currently reviewing and updating the quality strategy and quality priorities for the coming year. These will be based on themes identified in the recent CQC report as well as gap analysis of ongoing trends from other internal sources.

Executive Summary – 999 Operational Context

The scorecard below provides an overview of the Operational performance of the Trust in October. The Trust's response time performance was over the 7 minute target for C1 mean, and C2 was over the 18 minute target. C1 performance year to date is well under target for year to date figures as better performance becomes consistent.

The REAP levels have remained steady at level 2 and there have been no Surge plan triggered.

December 2019					Current Perfomance			Benchmarking*		
Indicator (KPI Name)	Basis	Data From Month	**Target Status**	**Statistical Process Control Icon**	Target	**Latest Month**	**Year To Date Actual**	National Data	Best In Class	**Ranking (out of 10)**
Category 1 response - Mean	mm:ss	Dec-19			07:00	07:15	06:37	07:28	06:46	1
Category 1 response - 90th centile	mm:ss	Dec-19			15:00	11:53	11:01	13:11	11:14	1
Category 2 response - Mean	mm:ss	Dec-19			18:00	26:59	20:15	26:02	14:31	4
Category 3 response - Mean	h:mm:ss	Dec-19			1:00:00	1:30:39	1:02:58	1:23:48	0:56:33	5
Category 4 response - 90th centile	h:mm:ss	Dec-19			3:00:00	4:11:07	3:26:43	3:47:24	1:11:37	7
Call answering - 999 (less than 5 seconds)	%	Dec-19				84%	81%			

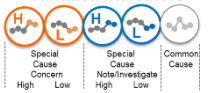
KPI on or ahead of target

KPI off target but within agreed threshold

KPI off target and outside agreed threshold

KPI not reported / measurement not started

Variation Indicators



Executive Summary – 999 Quality Summary Scorecard

London Ambulance Service NHS Trust

Dec-19

Indicator (KPI Name)	Basis	Data From Month	Target Status	Current Perfomance: Target	Current Perfomance: Latest Month	Current Perfomance: Year To Date Actual	Benchmarking: National Data	Benchmarking: Best In Class	Benchmarking: Ranking (out of 10)
Rate of Patient related Adverse Events per 1,000 Incidents	Rate	Dec-19		5.0	3.7	3.8			
Patient related Adverse Events - NO HARM	Count	Dec-19		250	350	2878			
Patient related Adverse Events - LOW	Count	Dec-19		20	30	347			
Patient related Adverse Events - MODERATE	Count	Dec-19		N/A	9	89			
Patient related Adverse Events - SEVERE	Count	Dec-19		N/A	5	42			
Patient related Adverse Events - DEATH	Count	Dec-19		N/A	11	61			
Medication Errors as % of Patient Adverse Events	%	Dec-19		N/A	8%	5%			
Needle Stick Injuries as % of Staff Adverse Events	%	Dec-19		N/A	0%	0%			
ROSC at Hospital (AQI)	%	Aug-19		30%	31%	34%			
ROSC at Hospital UTSTEIN (AQI)	%	Aug-19		55%	63%	59%			
STEMI to Angiography (AQI) (Mean)	hh:mm	Aug-19		N/A	02:10	02:08			
STEMI care bundle (AQI)	%	Jul-19		74%	70%	79%			
Stroke Call to Arrival at Hospital (AQI)	hh:mm	Aug-19		N/A	01:05	01:06			
Stroke on scene time (CARU continual audit)	hh:mm	Aug-19		00:31	00:31	00:30			
Survival to Discharge (AQI)	%	Aug-19		N/A	31%	34%			
Survival to Discharge UTSTEIN (AQI)	%	Aug-19		N/A	63%	60%			
STEMI- On scene duration (CARU continual audit)	hh:mm	Jul-19		N/A	00:31	00:30			

- KPI on or ahead of target
- KPI off target but within agreed threshold
- KPI off target and outside agreed threshold
- KPI not reported / measurement not started

Executive Summary – IUC Operational Context

London Ambulance Service NHS Trust

Audit hours – the number of hours available for Advanced Practitioner and GP audit has reduced. This has resulted in the required number of audits not being completed for all ACPs and GPs.

Accuracy of data – CMC flag and viewed data inaccurate. Technical End to End planned with CMC and HLP in January to ensure flagged and viewed records are reflected accurately.

Clinical Staffing – clinical staffing gaps (particularly at weekends) affecting timely call backs of CAS priorities. QGAM to review weekend staffing figures every Wednesday with Head of IUC Service Delivery to ensure potential mitigating activities are discussed with key stakeholders in advance of weekend.

December 2019

Indicator (KPI Name)	Basis	Data From Month	Target Status	Statistical Process Control Icon	Current Performance: Target	Current Performance: Latest Month	Current Performance: Year To Date Actual	Benchmarking*: National Data	Benchmarking*: Best In Class	Benchmarking*: Ranking (out of 10)
Call answering - NHS 111 SEL (less than 60 seconds)	%	Dec-19			>=95%	76.4%	77.6%			
Calls abandoned after more then 30 seconds- NHS IUC SEL	%	Dec-19			<5%	3.5%	3.6%			
Number of times SEL IUC went into Escalation Level 2	Count	Dec-19				5				
Number of times SEL IUC went into Escalation Level 3	Count	Dec-19				1				
Number of times SEL IUC went into Escalation Level 4	Count	Dec-19				0				
SEL Retriage Outcome- Ambulance	%	Dec-19				10%				
SEL % Ambulance avoided as a result of retriage	%	Dec-19				90%				
Call answering - NHS 111 NEL (less than 60 seconds)	%	Dec-19			<=95%	64.9%	78.5%			
Calls abandoned after more then 30 seconds- NHS IUC NEL	%	Dec-19			>5%	6.0%	3.80%			
Number of times NEL IUC went into Escalation Level 2	Count	Dec-19				21				
Number of times NEL IUC went into Escalation Level 3	Count	Dec-19				4				
Number of times NEL IUC went into Escalation Level 4	Count	Dec-19				0				
NEL Retriage Outcome- Ambulance	%	Dec-19				8%				
NEL % Ambulance avoided as a result of retriage	%	Dec-19				92%				

KPI on or ahead of target

KPI off target but within agreed threshold

KPI off target and outside agreed threshold

KPI not reported / measurement not started

Variation Indicators

Executive Summary – IUC Quality Summary Scorecard

London Ambulance Service NHS Trust

Dec-19

	Indicator (KPI Name)	Basis	Data From Month	Target Status	Current Perfomance: Target	Current Perfomance: Latest Month	Current Perfomance: Year To Date Actual	Benchmarking: National Data	Benchmarking: Best In Class	Benchmarking: Ranking (out of 10)
SEL	Rate of Patient related Adverse Events per 1,000 Calls	Rate				0.6	1.24			
SEL	Patient related Adverse Events - NO HARM	Count				28	372			
SEL	Patient related Adverse Events - LOW	Count				0	7			
SEL	Patient related Adverse Events - MODERATE	Count				0	2			
SEL	Patient related Adverse Events - SEVERE	Count				0	0			
SEL	Patient related Adverse Events - DEATH	Count				0	0			
SEL	Number of Serious Incidents Declared in SEL	Count				0	2			
SEL	Number of Quality Alerts being received regarding SEL Operations	Count				4	113			
SEL	Number of Quality Alerts received regarding SEL Operation Upheld	Count				0	52			
SEL	Average time to call-back per priority- SEL Priority 1	hh:mm				**	**			
SEL	Average time to call-back per priority- SEL Priority 2	hh:mm				**	**			
SEL	Average time to call-back per priority- SEL Priority 3	hh:mm				**	**			
NEL	Rate of Patient related Adverse Events per 1,000 Calls	Rate				1.4	1.15%			
NEL	Patient related Adverse Events - NO HARM	Count				86	494			
NEL	Patient related Adverse Events - LOW	Count				1	8			
NEL	Patient related Adverse Events - MODERATE	Count				1	4			
NEL	Patient related Adverse Events - SEVERE	Count				0	0			
NEL	Patient related Adverse Events - DEATH	Count				1	2			
NEL	Number of Serious Incidents Declared in NEL	Count				2	6			
NEL	Number of Quality Alerts being received regarding NEL Operations	Count				4	63			
NEL	Number of Quality Alerts received regarding NEL Operation Upheld	Count				2	44			
NEL	Average time to call-back per priority- NEL Priority 1	hh:mm				**	**			
NEL	Average time to call-back per priority- NEL Priority 2	hh:mm				**	**			
NEL	Average time to call-back per priority- NEL Priority 3	hh:mm				**	**			

- KPI on or ahead of target
- KPI off target but within agreed threshold
- KPI off target and outside agreed threshold
- KPI not reported / measurement not started

1. Safe

We must ensure we protect our patients and staff from abuse and avoidable harm. Our overall performance in this area over the past month is summarised by our Trust-wide Scorecard.

For further assurance we then provide additional data and analysis on:

- Patient Safety
- Infection Control
- Medicine Management
- Safeguarding
- Health and Safety

Outstanding Characteristic: *People are protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things go wrong.*

Patient Safety

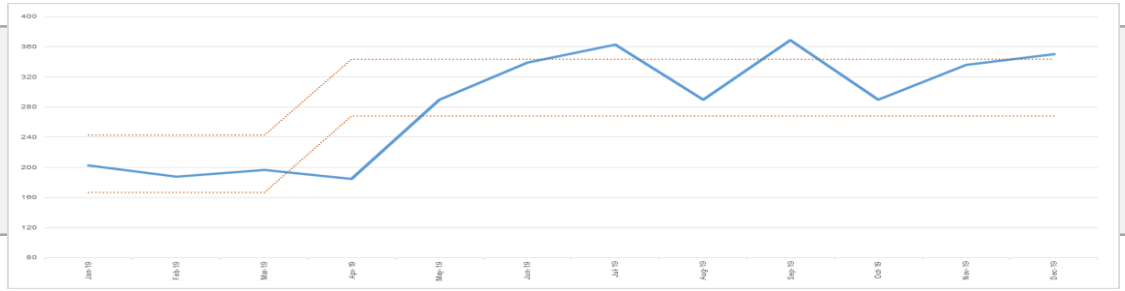
Owner: Helen Woolford | Exec Lead: Dr Trisha Bain

The total number of adverse patient events was 408 resulting in 3.7 events per 1000 incidents. The breakdown of these events is shown in the analysis below:

No Harm/Near Miss

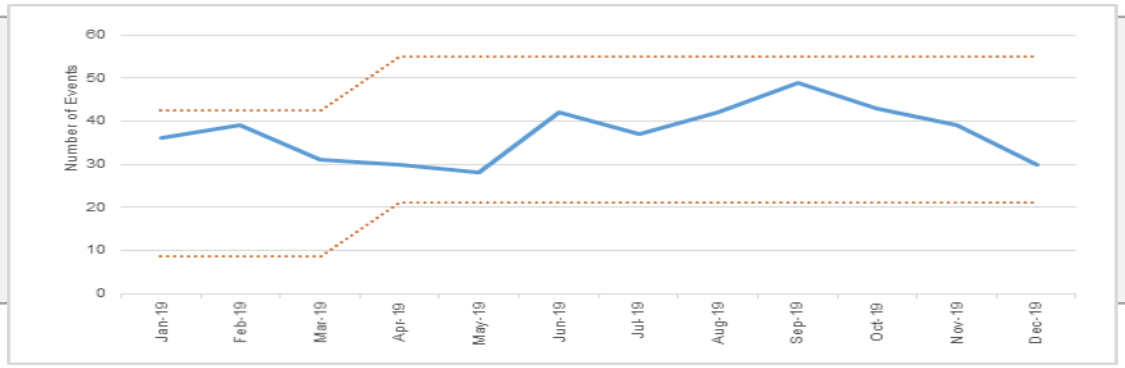
Latest Month: **350**

Monthly Trend



Low Harm

Latest Month: **30**



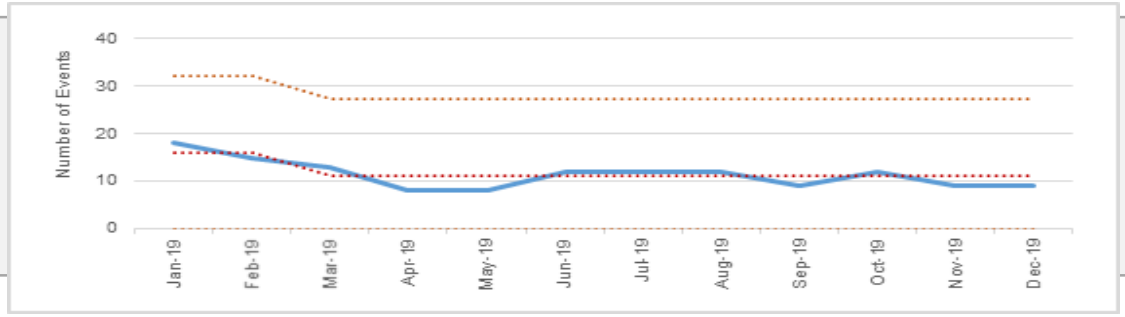
The Governance Department continues to encourage the reporting of all incidents.

The SPC charts have been updated and show a step change due to the increase in no/low harm incidents being reported.

Analysis indicates that we are likely to continue to see an increase in no harm and near miss incidents being reported, which is positive/

Moderate Harm

Latest Month: **9**



The SPC chart has been updated and shows that moderate harm incidents has slightly decreased. Analysis suggest that this is due to better understanding of harm levels and stronger scrutiny by the QGAMs and central governance team of these incidents.

Data Source:

CHART KEY
- Monthly value
- Target
- Mean (Baseline FY17/18)
- Upper and Lower Limit (Baseline FY17/18)

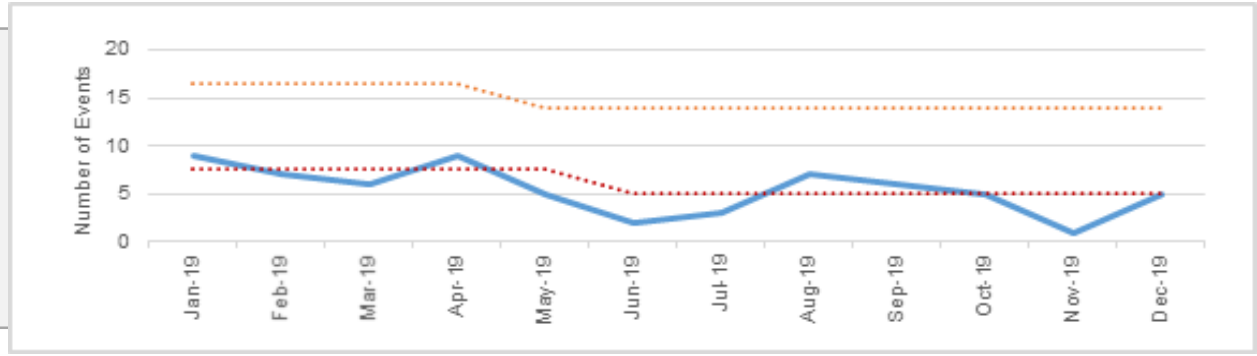
Patient Safety

Owner: Helen Woolford | Exec Lead: Dr Trisha Bain

Monthly Trend

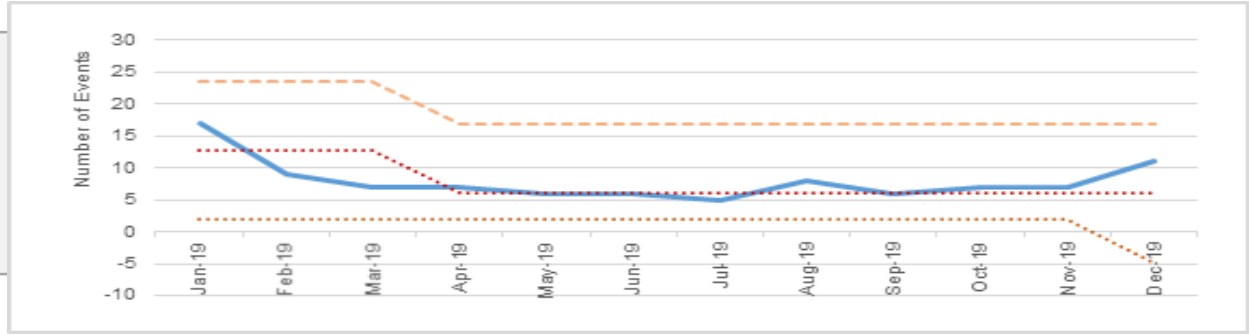
Severe

Latest Month: 5



Death

Latest Month: 11



The SPC charts for severe and death incidents have been updated and show a decrease in these incidents.

Analysis suggest that this is also due to better understanding of harm levels and stronger scrutiny by QGAMs and the central governance team.

Data Source:

CHART KEY
- Monthly value
- Target
- Mean (Baseline FY17/18)
- Upper and Lower Limit (Baseline FY17/18)

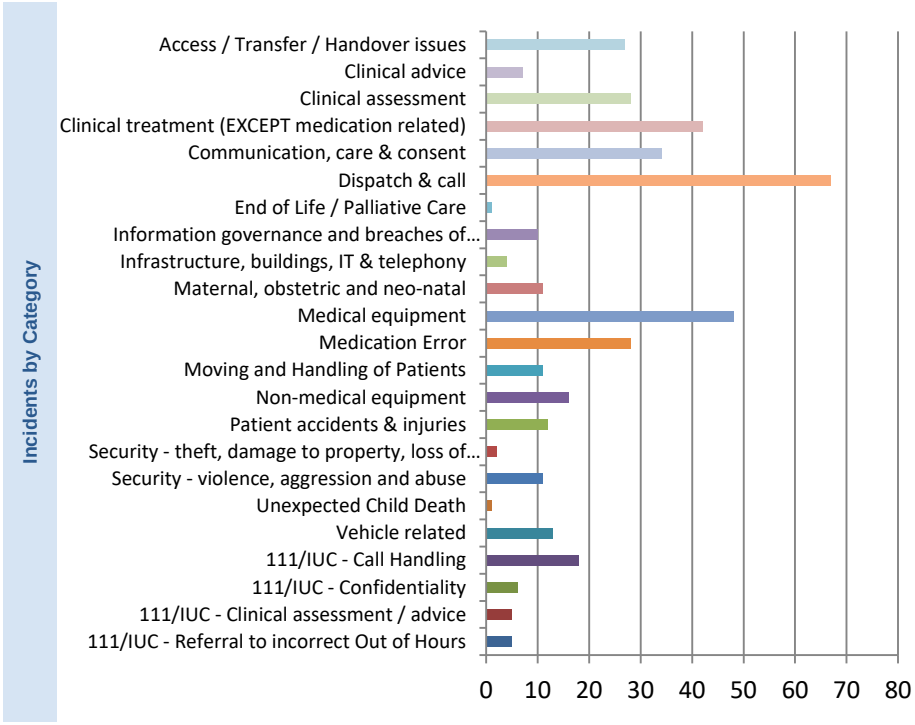
Owner: Helen Woolford | Exec Lead: Dr Trisha Bain

Below are our incident themes, action being taken to address them and how we share the learning from these across the Trust.

Incident Themes

Medical Equipment, dispatch and call management and clinical treatment issues remain the recurring themes albeit low numbers proportionally to the overall call volume.
Actions are being taken to address these themes including:

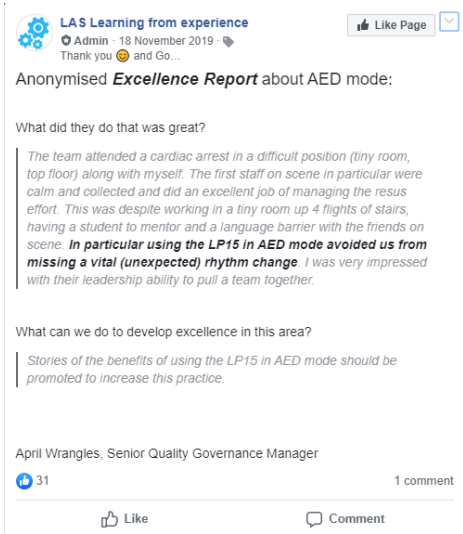
- Information being circulated regarding the faulty equipment process for timely repair of equipment.
- Call and dispatch incidents are being reviewed daily and the Chief Medical Officer is maintaining daily oversight of delays to assess any potential harm.



Learning

Listening into Action – The team have used an internal closed social media platform to promote key learning messages from incidents.

This has included; delayed defibrillation, management of hypothermic cardiac arrests and staff roles and responsibilities when commencing duty. These post have been well received and generated positive discussion.
A sample of some of these posts are below:


LAS Learning from experience
Admin · 18 November 2019 ·
Thank you and Go...
Like Page

Anonymised ***Excellence Report*** about AED mode:

What did they do that was great?

The team attended a cardiac arrest in a difficult position (tiny room, top floor) along with myself. The first staff on scene in particular were calm and collected and did an excellent job of managing the resus effort. This was despite working in a tiny room up 4 flights of stairs, having a student to mentor and a language barrier with the friends on scene. ***In particular using the LP15 in AED mode avoided us from missing a vital (unexpected) rhythm change****. I was very impressed with their leadership ability to pull a team together.*

What can we do to develop excellence in this area?

Stories of the benefits of using the LP15 in AED mode should be promoted to increase this practice.

April Wrangles, Senior Quality Governance Manager

31 1 comment

Like Comment


LAS Learning from experience
Admin · 18 November 2019 · Clinical discussion
Like Page

Cold Weather Alert

As the weather starts to get colder please remember the specific guidelines in relation to hypothermic patients

RISK FACTORS FOR HYPOTHERMIA:

- Older patients > 80 years
- Children
- Some medical conditions (hypothyroidism, stroke etc)
- Intoxicated patients
- Immobility and injury
- Decreased level of consciousness
- In association with drowning and in patients exposed to cold, wet and windy environments especially is inadequately dressed

As the core body temperature falls there may be the development of cardiac arrhythmias, such as sinus bradycardia, AF, VF and asystole.

Attending a cardiac arrest, for most, is a rare event. Attending a cardiac arrest where the patient is hypothermic is even rarer.

Last winter 4 cases were reported where a patient in cardiac arrest received the incorrect cardiac arrest management

REMEMBER:

✔For hypothermic patients with a tympanic temperature less than 30, no drugs should be administered (regardless of the cause of the arrest).

✔On the rare occasion where hypothermia is believed to be the cause of the cardiac arrest and the patient presents in a shockable rhythm, 3 shocks should be delivered while on scene and the patient removed to the vehicle and transported. Shocks may be continued en route to hospital as appropriate.

For more information please check out your ✅ ***JRCALC + app*** or refer to ✅ ***Cardiac Care Circular 007***

April Wrangles, Senior Quality Governance Manager

58 2 comments

Like Comment

Owner: Helen Woolford | Exec Lead: Dr Trisha Bain

We must ensure we report, track and respond to serious incidents appropriately – the below analysis highlights the current trends around where our serious incidents are being reported, the current status of our response and where we still have outstanding actions to address as a Trust.

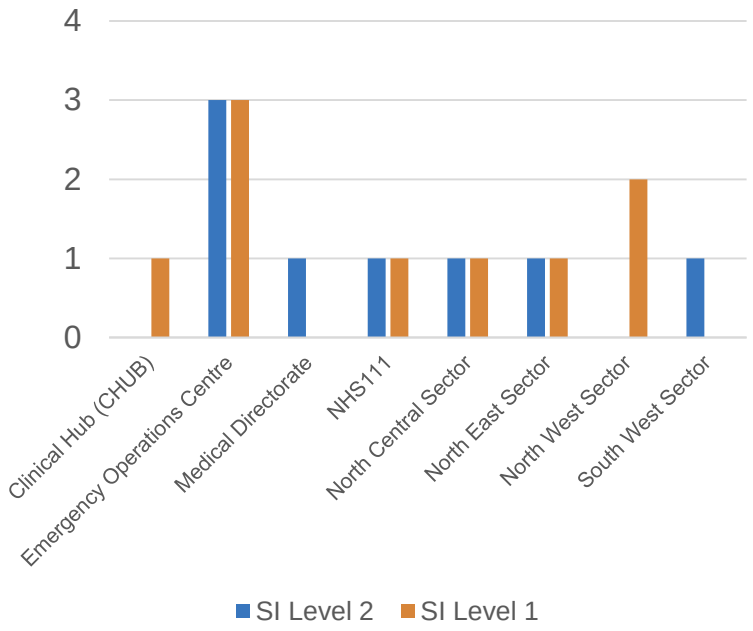
Serious Incidents

During December 2019, 17 reported incidents were declared as SIs after review at the Serious Incident Group (SIG). Fig. 1 shows the monthly distribution of declared SIs across the Trust.

Delayed Defibrillation Thematic Analysis – A second thematic analysis of delayed defibrillation was completed at the beginning of November.

The analysis reviewed 11 serious incident cases, identified 12 care and service delivery problems, generated 11 recommendations which have been transformed into 15 SMART actions. This action plan is being monitored through SIALG.

Monthly Analysis



Learning from Serious Incidents

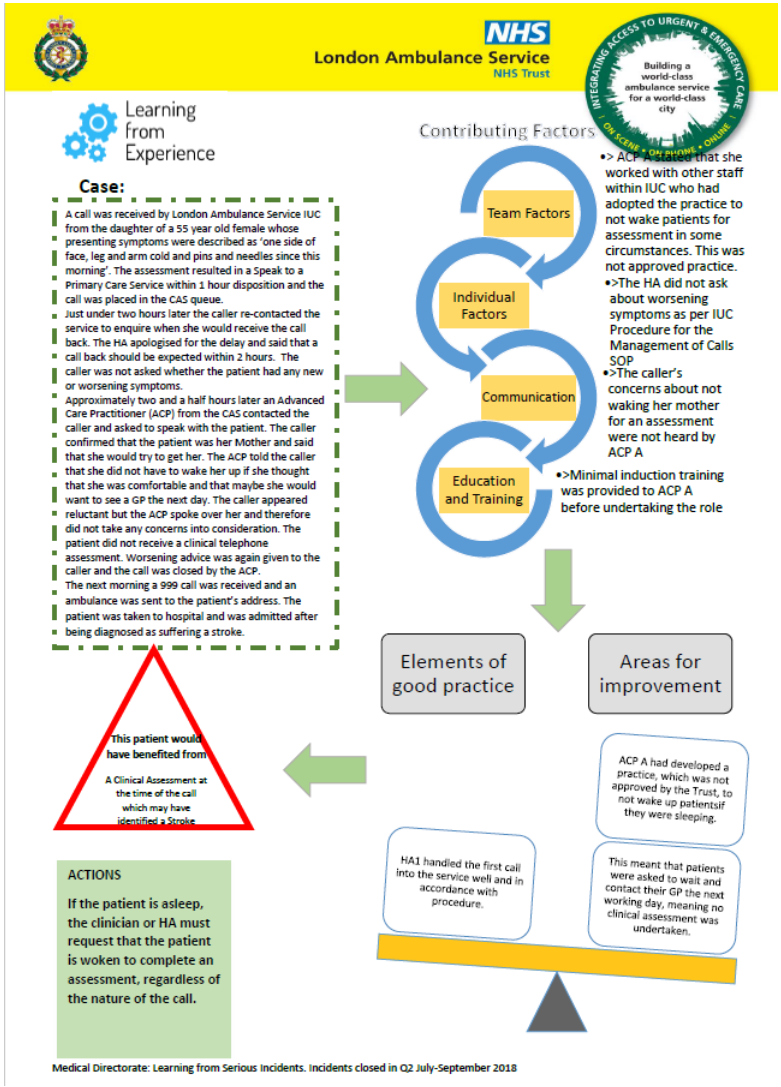
Insight magazine – The latest edition of INSIGHT magazine was released in November and included some of the learning found during Serious Incident investigations.

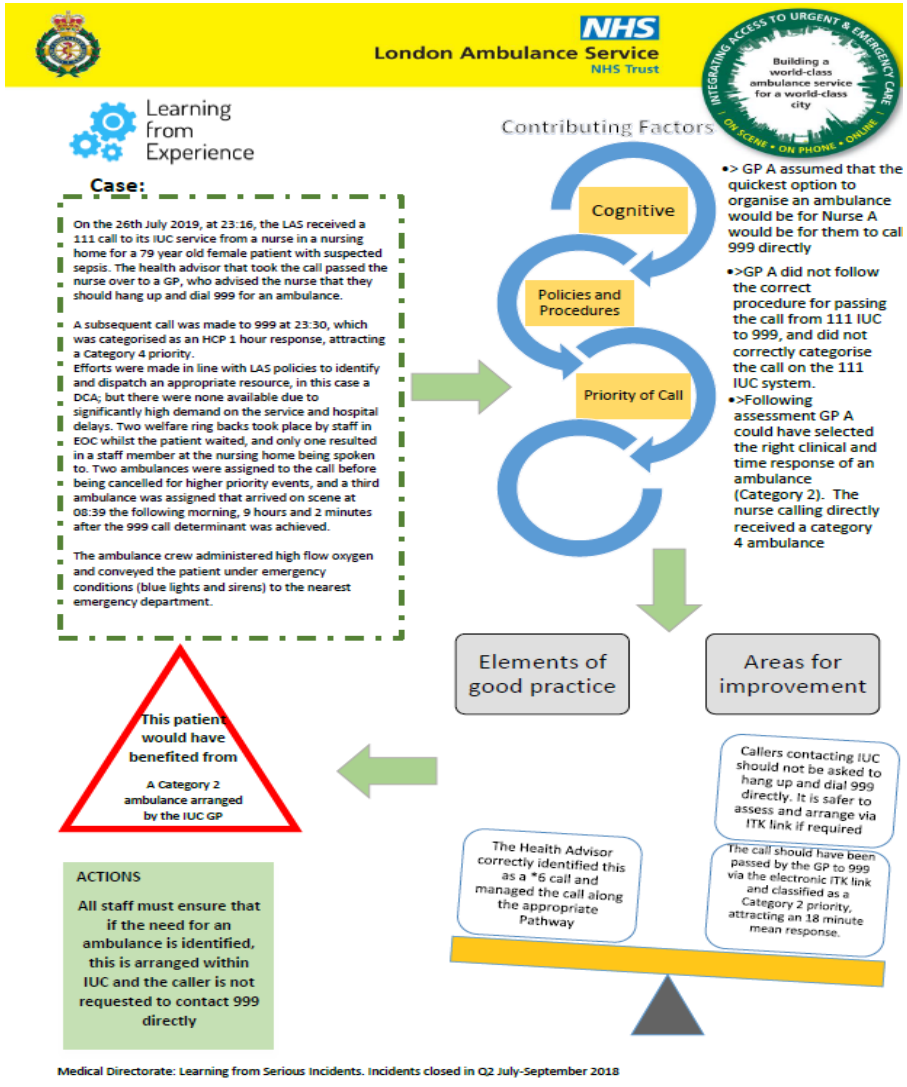
Topics covered included the recognition of ineffective breathing by Emergency Call Handlers, the importance of using decision making tools such as the falls decision tree; documentation of difficult conversations with patients and relatives when discussing non-conveyance and the associated risk factors; and the effect of confirmation bias during telephone triage in the IUC services.

Serious Incident Case Review Evening – This event took place at the end of November and staff from across the Trust were invited to attend and partake.
A total of 5 serious incidents were presented by their respective lead investigators who highlighted the key learning points for each case.

Topics included the confirmation bias associated with attending patients presenting with chest pain; the recognition of sepsis during telephone triage; mapping software issues; information governance breeches in the form of missing patient report forms; and delayed defibrillation.
The event was well attended and will run quarterly.

At the conclusion of incidents, a learning from experience infographic is distributed across both IUC services and EOC if applicable. 2 recent releases below





Below are our incident themes, action being taken to address them and how we share the learning from these across the Trust.

Incident Themes

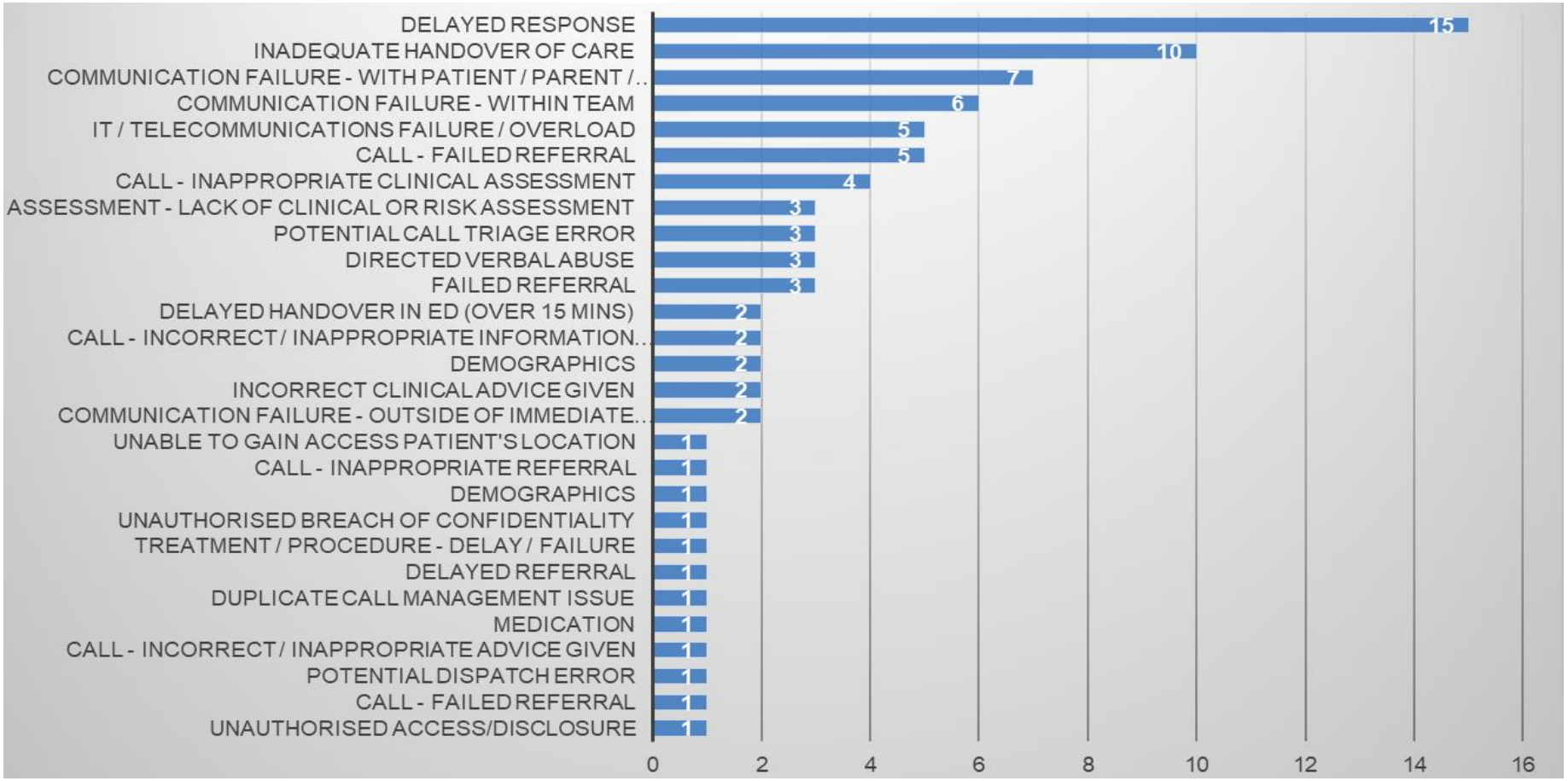
- Delayed Response to call back– Attributed to CAS Queue delays
- Inadequate Handover of Care – this could attribute to a failed referral that was not identified or the patient was referred to an inappropriate service
- Communication failure – this could be where the incorrect appointment location details were given by the HA to the patient resulting in attendance at the wrong location

Serious Incident Themes

In December, there were 2 incidents declared as SIs following review at the Serious Incident Group (SIG).

Of those declared SIs, 1 was declared Level 2 comprehensive investigation and 1 a Level 1 concise investigation.

Incidents by Category



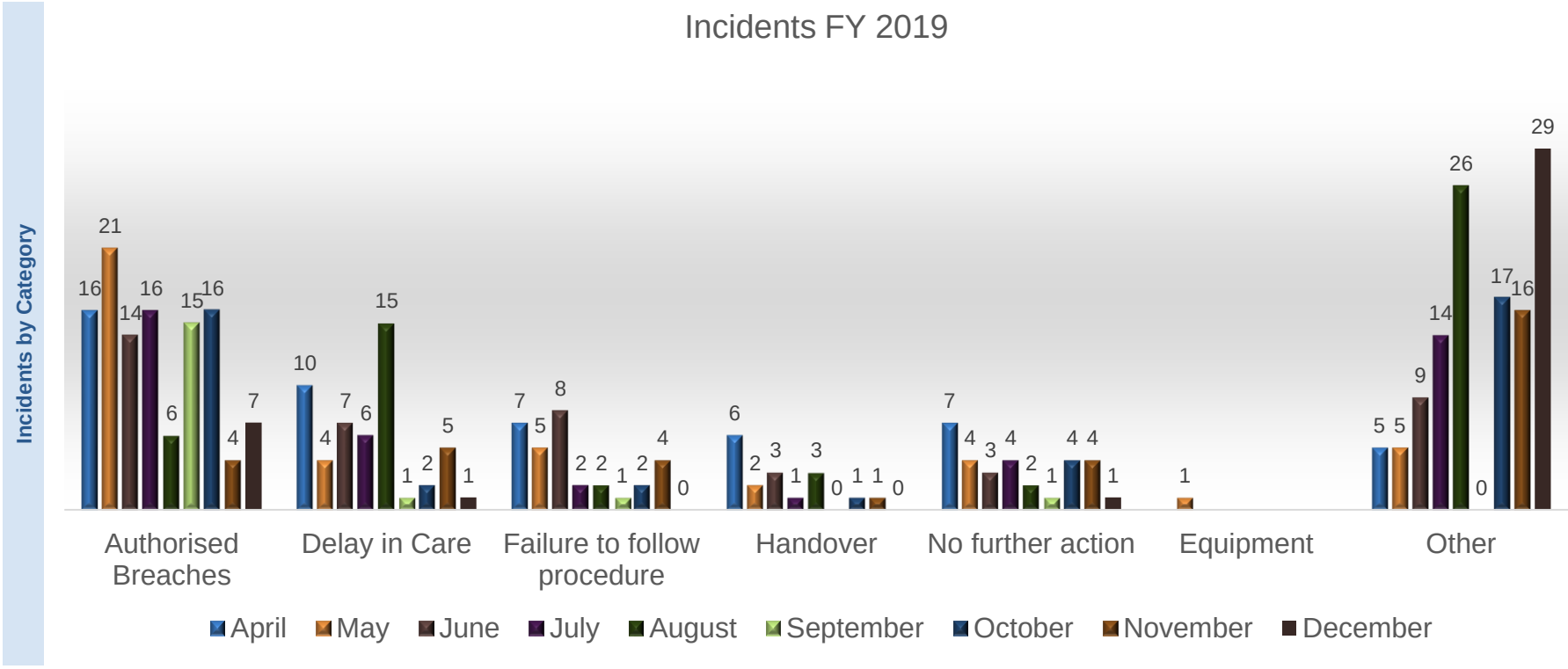
Below are our incident themes, action being taken to address them and how we share the learning from these across the Trust.

Incident Themes

- Authorised breaches remains the most common incident theme. All breaches of confidentiality (for example sending an ambulance without the patient's consent) are recorded as an incident in order for the clinical decision making and rationale to be reviewed to ensure it is appropriate.
- These reviews show consistently that breaches are all appropriate to the situation and are therefore categorised as authorised.

Serious Incident Themes

In December, there were 0 incidents declared as SIs following review at the Serious Incident Group (SIG).



Owner: Sharon Egdell | Exec Lead: Dr. Fenella Wrigley

Monthly IPC Training Compliance December 2019 (Target: 90%)

Data extracted from ESR system:

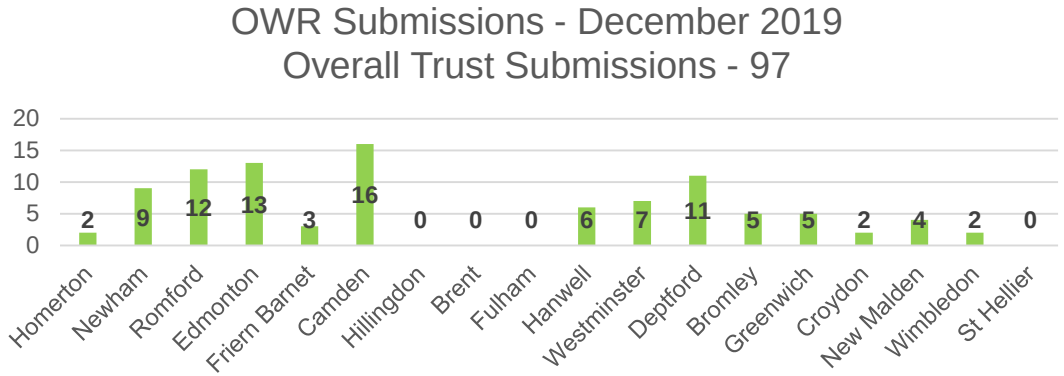
IPC training compliance for Level 1 and Level 2 is monitored via ESR .Compliance for December has exceeded the Trust performance target of 90% for both level 1 and 2

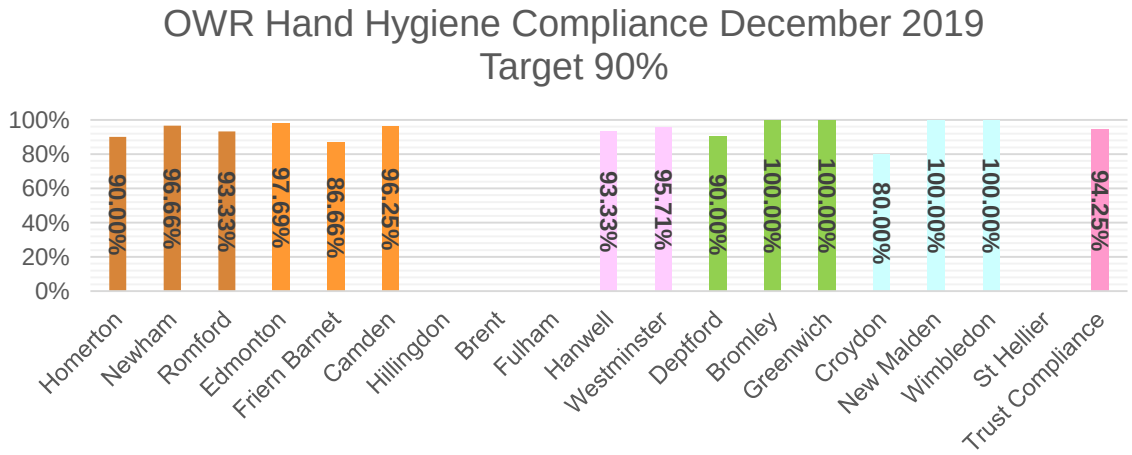
Performance achieved in December 2019:
- Level 1 – 96.83 % compared to 96.06% in November
- Level 2 – 96.92 % compared to 96% in November

Assurance:
- Monitored via ESR
- Monthly CEO performance reviews
- Oversight at Quarterly ICDG, IPCC and QOG

Actions taken:
- Nil new

Owner: Sharon Egdell | Exec Lead: Dr. Fenella Wrigley





- **Hand Hygiene Performance:**
  - **Data extracted from My assurance App:**
- 15/18 group stations submitted OWR data for December 2019, compared to 16/18 in November.

- Overall submissions have decreased for the third consecutive month to 97 , compared 116 in November and 168 in October 2019. Group stations manage their respective annual trajectory for OWR submissions and its is acknowledged by the IPC Committee that this may result in some monthly zero submissions throughout the year.

- Overall Trust OWR hand hygiene compliance for December 2019 has decreased to 94.25% when compared to 95% in November.. The compliance still exceeds the Trust target of 90%

- Compliance is at or above the expected Trust target of 90% for 13 of the 15 group stations that submitted data. Friern Barnet and Croydon failed to meet the required compliance of 90% .Compliance is monitored and managed at a local level.

- **Assurance**

- Monthly Quality Report, CEO Performance Reviews, Quarterly Sector Quality Meetings
- Oversight: Monthly by IPC service, through governance processes at quarterly ICDG, IPCC, and at QOG
- IPC Champion role to raise standards and ownership at local stations by providing practical Hand Hygiene at stations.

- **Actions**
- IPC Winter wellbeing messages were published on The Pulse News page in December , which included reminders of the importance of hand washing. Same messages also communicated on LAS Twitter and Facebook
- Hand Hygiene audits continue at A&E departments, being carried out by IPC team. Focusing on the WHO 5 moments.
- The IPC team have continued ride outs, which is a real time learning opportunity to observe practice and support staff to continually improve
- With effect from October 2019, OWR submissions have been submitted on the My assurance App, which enables Group management teams , including QGAM's to review data in real time and address compliance/ performance issues in a timely way.

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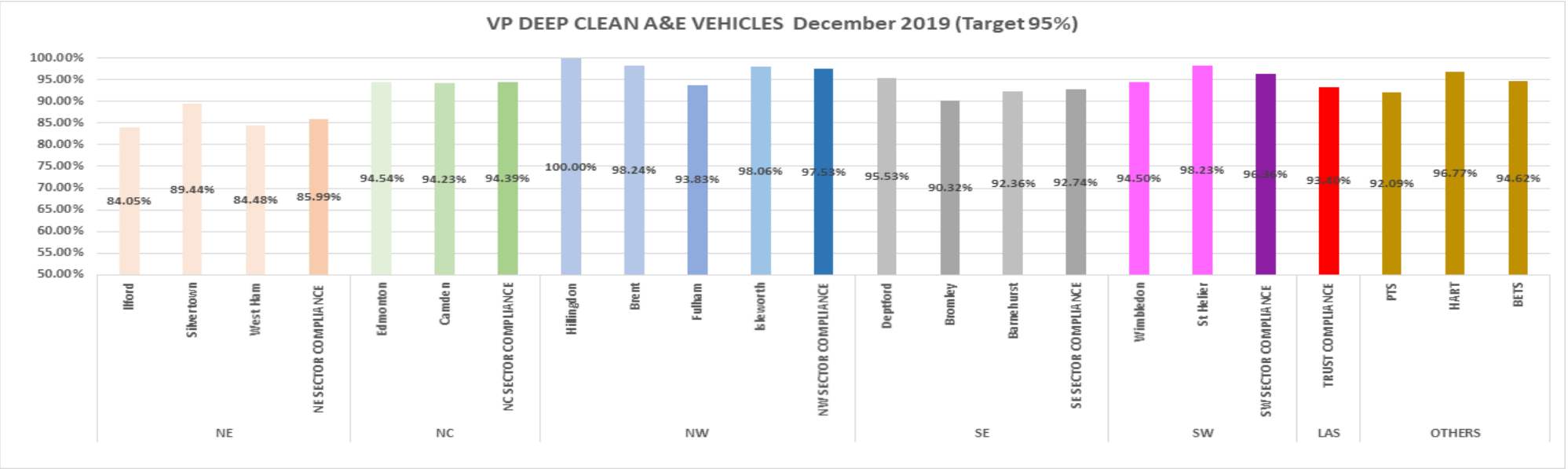
Owner: Sharon Egdell | Exec Lead: Dr. Fenella Wrigley



Performance

Data provided by the VP Contract Manager Mandy Green:

- Trust compliance has decreased to 93.4% , when compared to 96% in October and November 2019. This is below the Trust target of 95%. The VP contract manager has raised this with the contractor – vehicle availability, (due to operational demand), has been cited as the reason. This has reportedly impacted on the number of vehicles being available to go through the deep clean process..
- Performance is managed through formal contract meetings .

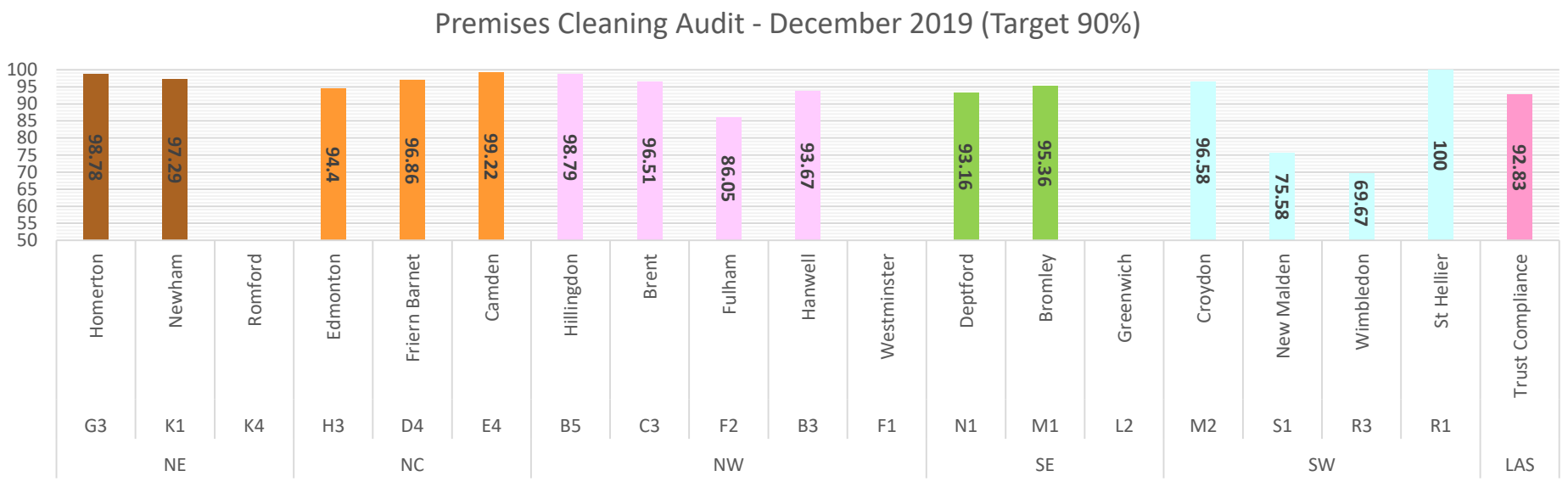
Assurance

- Monthly Quality Reporting and CEO Performance Reviews
- Oversight: Monthly by IPC service, through formal channels at quarterly ICDG, IPCC, and at QOG
- Logistics managers have regular contract meeting with contractors; action plan for low compliance; regular stakeholder meetings established

Actions

- Logistics to continue to monitor.
- IPC continue to monitor monthly.

Owner: Sharon Egdell | Exec Lead: Dr. Fenella Wrigley



Performance

Data extracted from My Assurance App:

- 15/20 Group Stations/Services submitted data for analysis, compared to 17/20 Group Stations submitting in November 2019
- New Malden, Wimbledon & Fulham have failed to achieve the required standard in December. The Facilities manager has raised this with the contractor to address
- Overall Trust compliance for November has shown a decrease for the second consecutive month, to 92.83% ,when compared to 93.25 % in November and 95.55% in October 2019. This score continues to exceed the Trust performance target of 90%

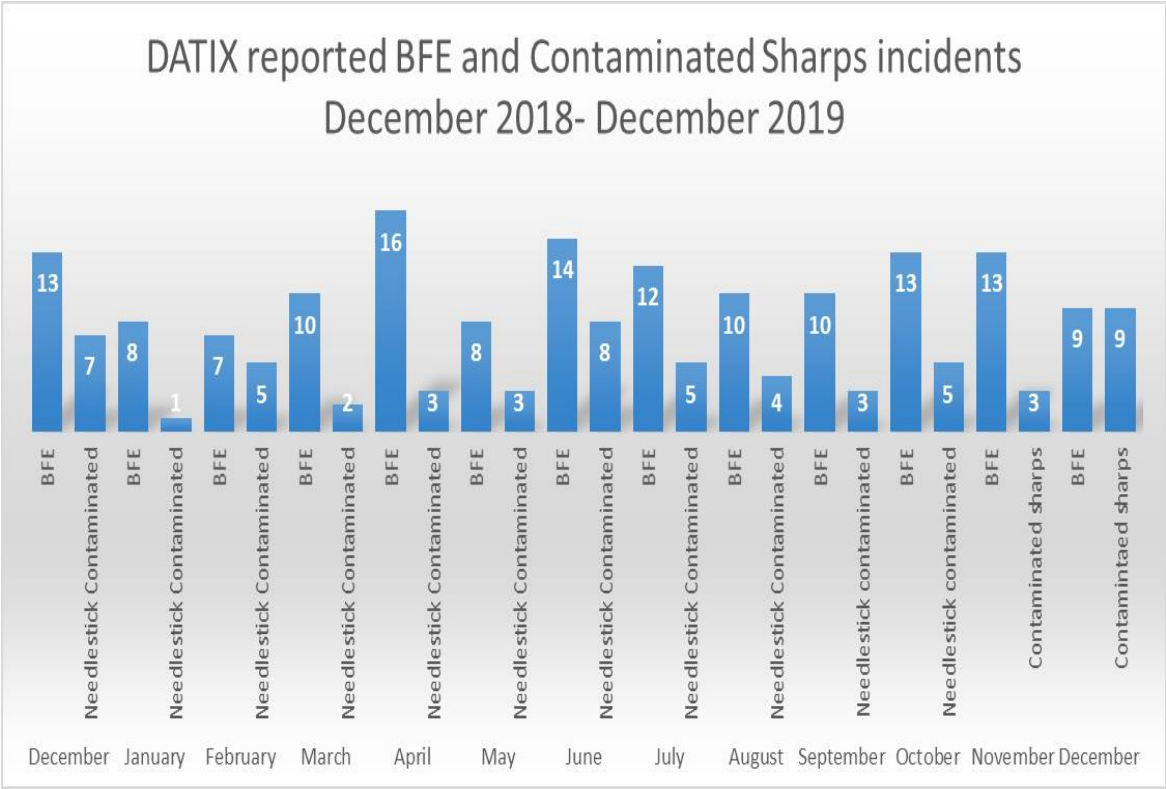
Assurance

- Monthly Quality Reporting and CEO Performance Reviews
- Oversight: Monthly by IPC service and through governance processes at quarterly ICDG, IPCC, and at QOG
- Estate contract managers have regular contract meeting with contractors; Contract managers and Contractors also undertake audits to ensure standards are maintained

Actions

- With effect from October 2019 data set, station cleaning audits were submitted on the My assurance App, which enables Group management teams to review data in real time and address any issues in a timely way

Owner: Sharon Egdell | Exec Lead: Dr. Fenella Wrigley



Performance

Data extracted from DATIX system:

- The reported data of 18 incidents is for contaminated sharps and BFE only- *clean sharps incidents have been extracted as these fall within Health & Safety remit, not IPC*
- 9/18 incidents reported in December were as a result of exposure to body fluids (BFE)
- 9/18 incidents reported in December were as a result of contaminated sharps injuries

Themes:

- BFE incidents:
  - Body fluid splashes to eyes and mouth- no facial PPE worn
  - Cannula splashback to eyes/ mouth- no facial protection worn

- Contaminated sharps incidents:
  - Failed cannulation
  - Sharps box not available at point of care
  - Agitated patient

Assurance

- Monthly oversight by IPC team, Monthly Quality Reports, Quarterly Sector Report, Quarterly ICDG/IPCC/QOG oversight.
- Datix incident follow-up and Datix Risk Reporting.

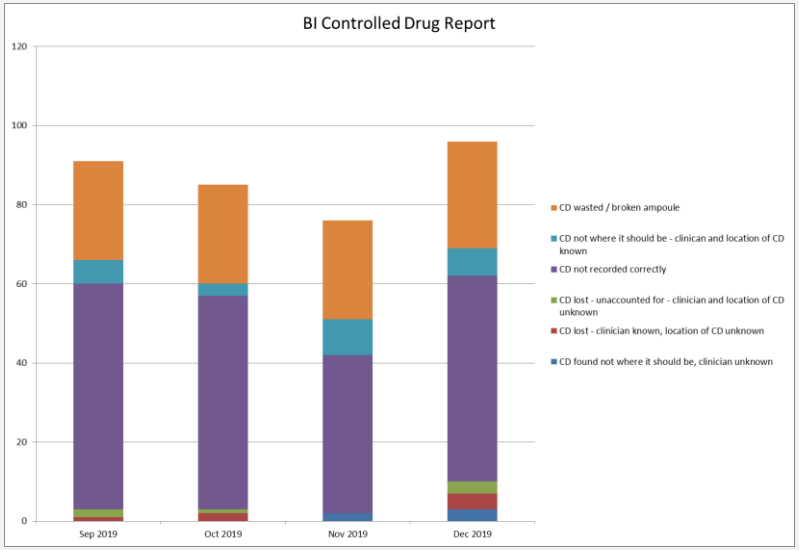
Actions:

Nil new actions in December

Medicines Management

Owner: Timothy Edwards | Exec Lead: Dr. Fenella Wrigley

Medicines Management



- No unaccounted for loss of injectable morphine
- Total of 92 other controlled drug (CD) incidents including
  - Documentation errors (n=53)
  - Morphine retained off duty (n=5)
  - Breakage/wastage (n=27) or inadequate volume (n=1)
  - CD unsecured (n=2)
  - CD left at scene (n=4)
- Non-controlled drugs (schedule 2) incidents
  - Documentation error (n=4)
  - Breakage or wastage (n=7)
  - Kitprep discrepancy (n=8)
  - Packing error (n=1)
  - Prescribing error by another healthcare professional (n=3)
  - Loss or theft (n=7)
  - Packing error (n=1)
  - Inadequate drug/gas supply (n=2) or drugs expired (n=1)
  - Drugs unsecured (n=3) or cold chain breach (n=1)
  - Errors in administration of adrenaline 1:10,000 (n=3), 1:1,000 (n=1), aspirin (n=1), hydrocortisone (n=1), dexamethasone (n=2), diazepam (n=2), midazolam (n=1), morphine (n=3), entonox (n=1), TXA (n=1).

Actions

- First places awarded to APP-UC staff on prescribing modules for HEE pilot
- Implementation of JRCALC Plus App supporting medicines guidelines
- New PGDs to expand range of APP drugs finalised.
- Drugs administration errors followed up by local management teams with staff and resolved.
- External prescribing errors reported to and followed up with other organisations.
- PGD breaches considered via the serious incident group

Assurance

- Limited occasions where morphine retained off duty and all incidents identified in a timely fashion.
- Rapid identification of potential diversion and investigations supported by use of CCTV and secure drug room technologies.

Data Source: Datix

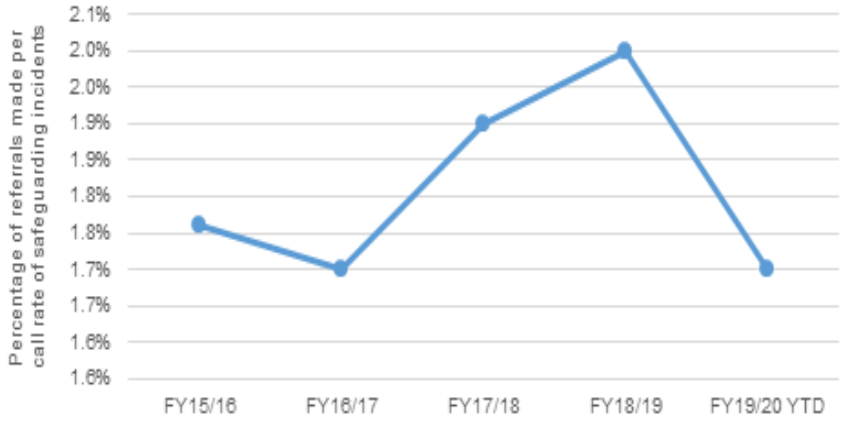
Safeguarding

Owner: Alan Taylor | Exec Lead: Dr. Trisha Bain

Referrals

Monthly Rate: 1.7%

Missed Referrals: 3



The referrals rate for December was 1.7%. The referral rate is below the expected level of between 1.8% and 2.5%. This is due to the change in practice with welfare care concerns, empowering individuals to raise own concerns. Target will be readjusted for 2020-21

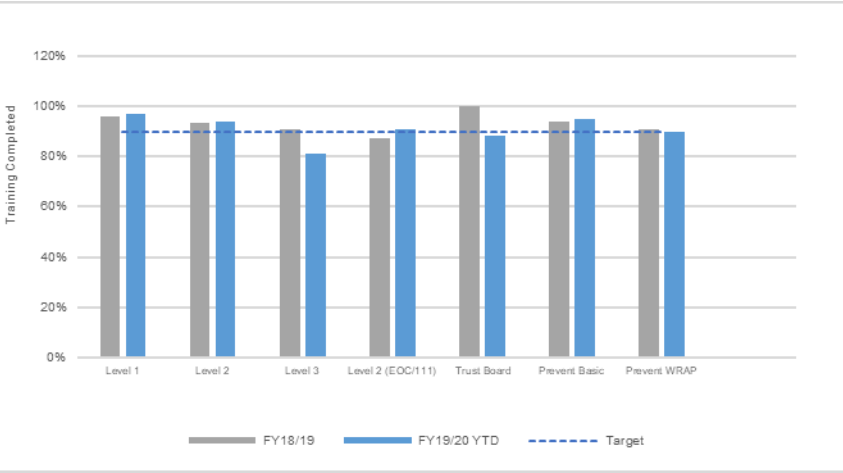
Missed Referrals (which is a shadow KPI) was 3.

Delivery of Training

Level 1: 97%

Level 2: 94%

Level 3: 81%



Level 3 is 81% of trajectory of 800 by end of 2019-20. Sufficient courses are planned to enable trust to meet requirement.

Trust Board training delivered in December 2 members outstanding.

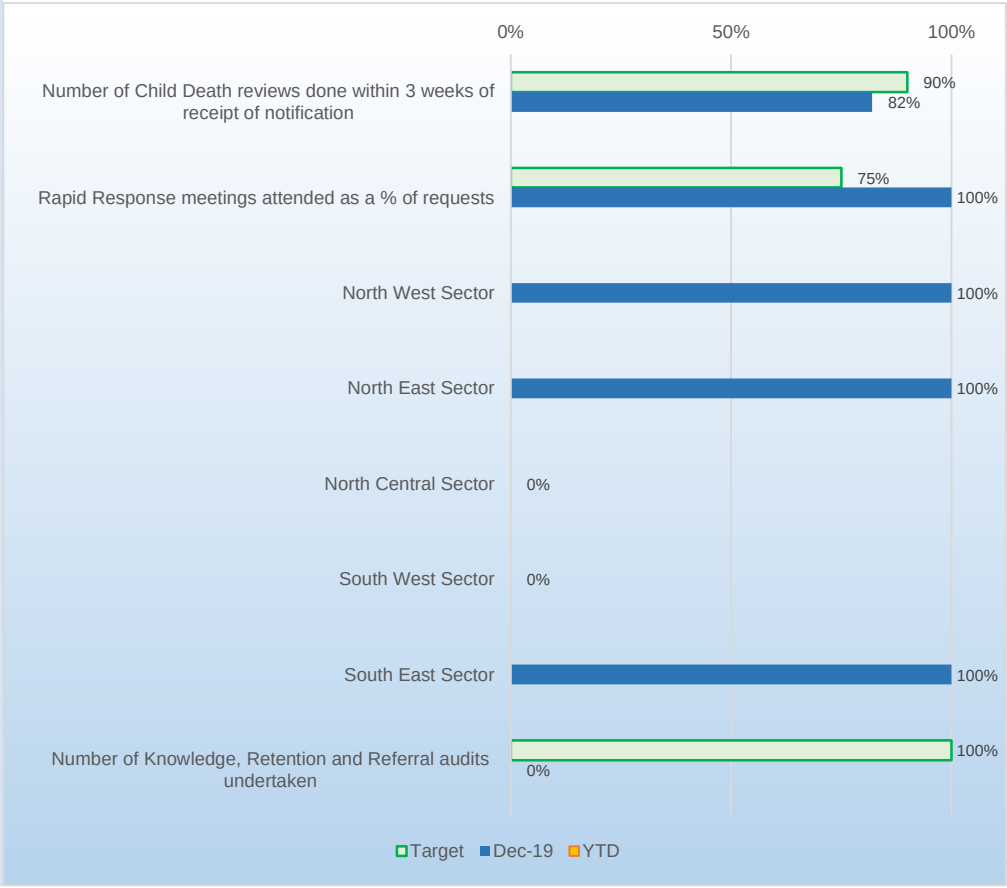
Data Source:

Safeguarding

Owner: Alan Taylor | Exec Lead: Dr. Trisha Bain

Safeguarding KPIs remain on track and are monitored closely by the Safeguarding Assurance Group.

Review, Response and Audit



Child Deaths Reviews 82%. This is out of target and due to a delay in PRFs being put onto the system and Clinical Lead capacity over the Christmas period.

Rapid Response meetings attended as a percentage of requests was below the target of 100%. NW 5/5 NC 0/0, NE 4/4 SE 2/2, SW 0/0.

Data Source:

Owner: Alan Hay | Exec Lead: Trisha Bain

Safeguarding for December 2019

Figures reported for NEL IUC CAS Referrals

Safeguarding – November 2019

No. of referrals	Adult	Children	Theme identified and outcome learning and improvements made
49	16	33	Variety of themes, linked to social care issues and notification of contact by children known to a service. Wider system development to provide improved theme reporting. The categories of referral are multi-choice; an individual referral might have two or three categories ticked (for example neglect and domestic violence) – so those totaled up come to more than the number of adult referrals. 'Other borough not listed' are mostly out of London boroughs where a patient has either travelled into London, or sometimes where a looked-after child has been placed with a London borough, but their plan is held in a distant borough. Ordinarily both boroughs are informed, but only one can be recorded in Datix. Drop in volumes but it's been a quieter month for safeguarding generally.

NE 111 IUC

	Adult - 18	Child - Un	Total
Barking and Dagenham	5	7	12
Enfield	0	1	1
Hackney	2	3	5
Havering	2	3	5
Lewisham	0	1	1
Merton	1	0	1
Newham	1	5	6
Redbridge	2	7	9
Tower Hamlets	1	4	5
Waltham Forest	1	2	3
Other borough not listed	1	0	1
Total	16	33	49

NE	
Adult SG	11
Adult Welfare	5
Child	33
Other outcome	4
Total	53

Child Safeguarding	NE111
Physical abuse	2
Neglect	8
Domestic violence / abuse	2
Parental capability	10
Emotional abuse	1
Mental health / Self-harm / Suicidal	4
Parental mental health	1
Intoxication	1
On plan / Looked after only	3

Adult Safeguarding	NE111
Physical abuse	2
Self-neglect (including hoarding)	1
Domestic violence	1
Financial or material abuse	2
Neglect and acts of omission	6

Safeguarding for December 2019

Figures reported for SEL IUC CAS Referrals

Safeguarding – November 2019			
No. of referrals	Adult	Children	Theme identified and outcome learning and improvements made
64	23	41	Variety of themes, linked to social care issues and notification of contact by children known to a service. Wider system development to provide improved theme reporting. The categories of referral are multi-choice; an individual referral might have two or three categories ticked (for example neglect and domestic violence) – so those totaled up come to more than the number of adult referrals. 'Other borough not listed' are mostly out of London boroughs where a patient has either travelled into London, or sometimes where a looked-after child has been placed with a London borough, but their plan is held in a distant borough. Ordinarily both boroughs are informed, but only one can be recorded in Datix. Drop in volumes but it's been a quieter month for safeguarding generally.

	Adult - 18 years or older	Child - Under 18 years	Total
Bexley	0	2	2
Bromley	4	3	7
Greenwich	3	4	7
Havering	0	2	2
Lambeth	6	6	12
Lewisham	3	8	11
Newham	0	1	1
Southwark	6	7	13
Sutton	0	1	1
Tower Hamlets	0	1	1
Waltham Forest	1	0	1
Wandsworth	0	1	1
Other borough not listed	0	5	4
Total	23	41	64

Child Safeguarding	SE111
Physical abuse	1
Neglect	2
Domestic violence / abuse	1
Parental capability	5
Emotional abuse	2
Mental health / Self-harm / Suicidal	8
Parental mental health	5
Intoxication	1
On plan / Looked after only	15

Adult Safeguarding	SE111
Physical abuse	3
Psychological abuse	2
Self-neglect (including hoarding)	5
Domestic violence	2
Financial or material abuse	1

Health and Safety

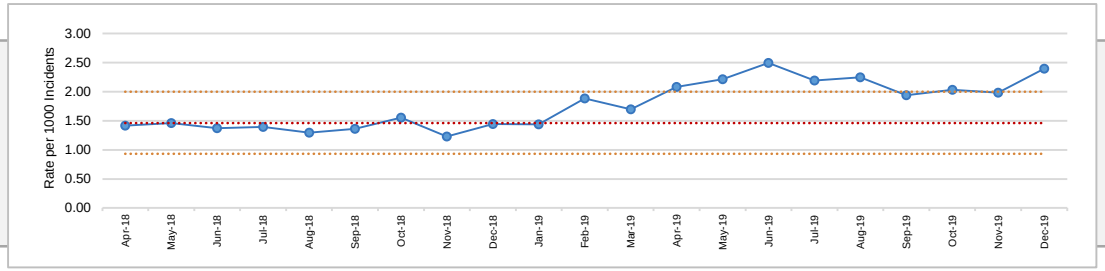
Owner: Edmund Jacobs | Exec Lead: Dr Trisha Bain

*The total number of H&S incidents was 386 resulting in **3.76 events per 1000 (face to face) attendances**. The breakdown of these events is shown in the analysis below:*

Monthly Trend

No Harm / Near Miss

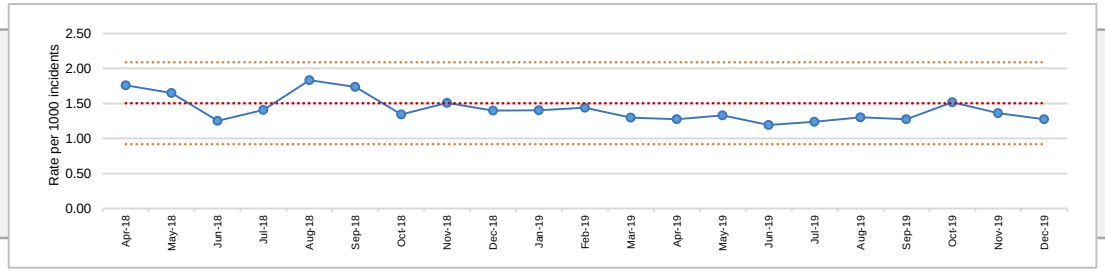
Month: 2.40



246 (64%) of the H&S related incidents reported during December - 2019 resulted in No Harm/Adverse/Near Miss.

Low Harm

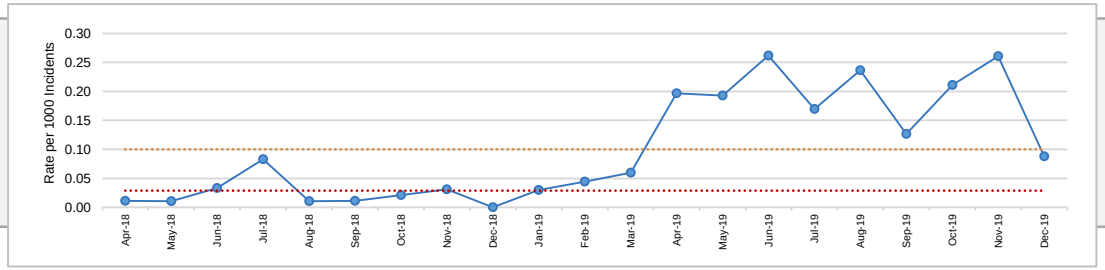
Month:1.28



131 (34%) of the H&S related incidents reported during December - 2019 resulted in Low Harm.

Moderate

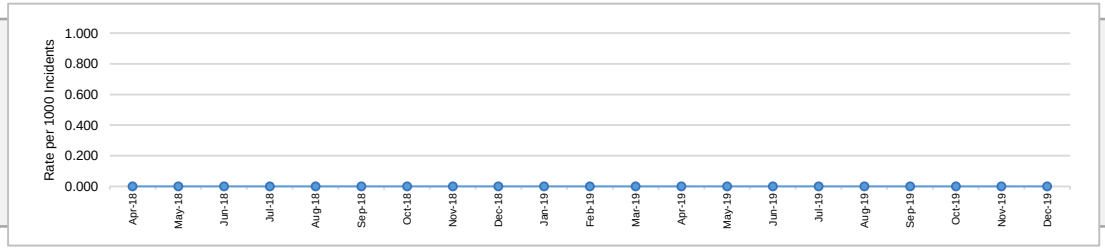
Month: 0.09



9 (2%) of the H&S related incidents reported during December - 2019 resulted in Moderate Harm.
In line with the Trust Risk Management Strategy all RIDDOR incidents are graded as minimum moderate harm, this also aligns with the HSE RIDDOR requirements. This will help ensure management attention is focussed on proportionate interventions.

Severe

Month: 0



There was no incident reported as Severe Harm during December – 2019.

CHART KEY
Monthly value
Mean (Baseline FY17/18)
Upper and Lower Limit (Baseline FY18/19)

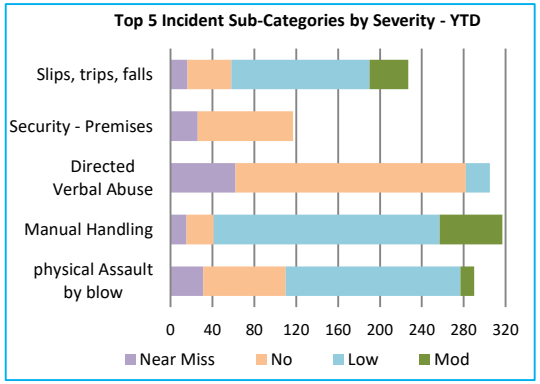
Data Source:

Owner: Edmund Jacobs | Exec Lead: Dr Trisha Bain

Understanding the root cause of the health and safety events that occur for our staff can help us ensure we put in place the necessary training and actions to ensure we manage any risks to the well being of our staff – the analysis below looks at **1)** Incident Causes **2)** Assaults on Staff by Patients and **3)** RIDDOR Incidents

Incident Causes

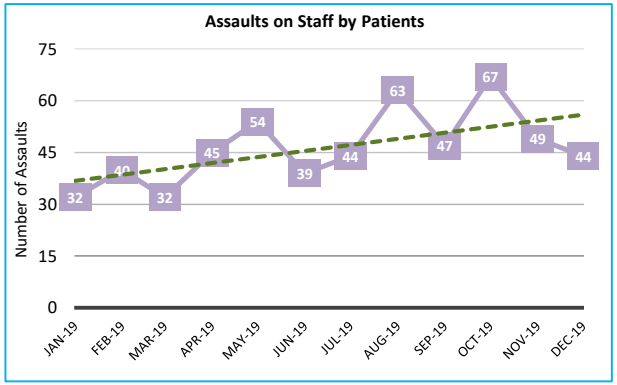
Top 5 Incident Causes



- Manual Handling (lifting patients), Directed verbal abuse and Physical Assault by blow (kick, punch, push etc incidents account for the highest numbers reported during December 2019.
- There has been a rise in incidents related to tail lift failures and staff injury (MSK) as a result. Working with Fleet to produce bulletins and training material to remind staff of correct techniques.

Assaults on Staff

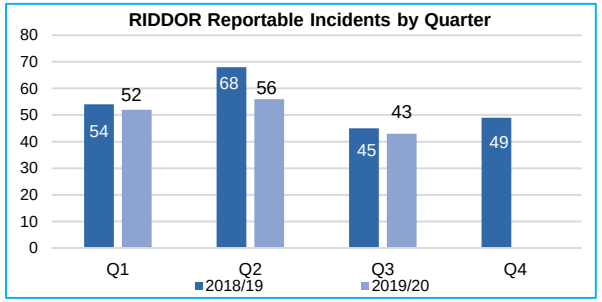
Assaults on Staff



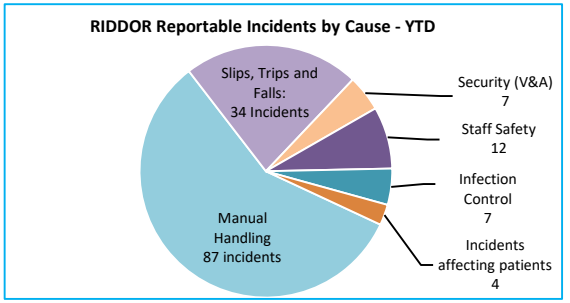
- There was a slight decrease in the number of assaults on staff by patient related incidents in December 2019 but the trend is up-ward.
- The most common underlying causes remain: intoxication (drugs/alcohol), Mental Health related issues, patients recovering from fits/seizures or reacting to medication.

RIDDOR Incidents

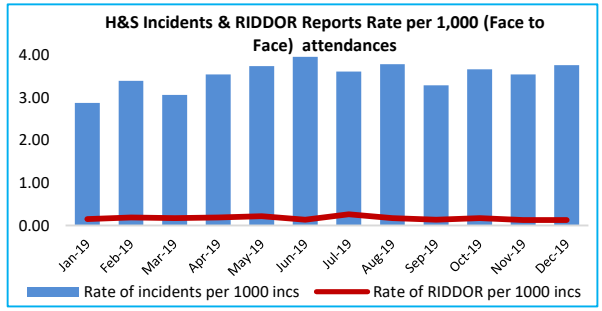
Number of incidents



RIDDOR by cause

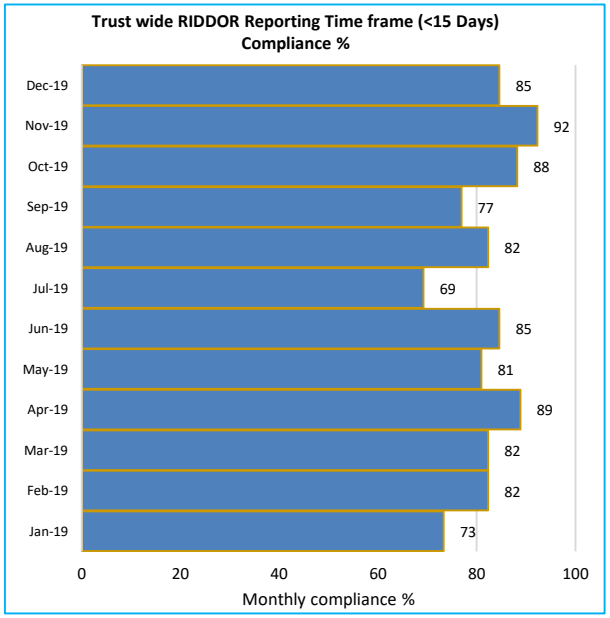


Rate of Incidents



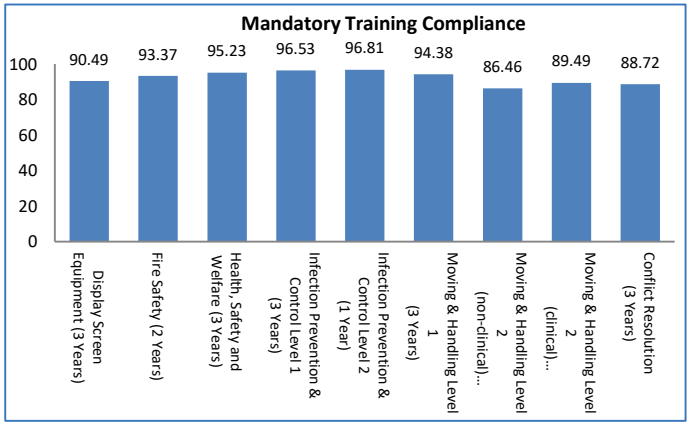
- Total of 151 RIDDOR incidents reported to the HSE during 2019/20 (up to end of December'19)
- Total of 13 RIDDOR incidents reported to the HSE during December'19.
- 2 out of the 13 incidents reported outside the 15 days timeframe during December'19.
- The Trust wide RIDDOR reporting time frame (<15 days) compliance in December'19 was **85%.**
- Manual Handling & incidents account for the highest number of RIDDORs reported across the Trust during 2019/20 (up to end of December'19).

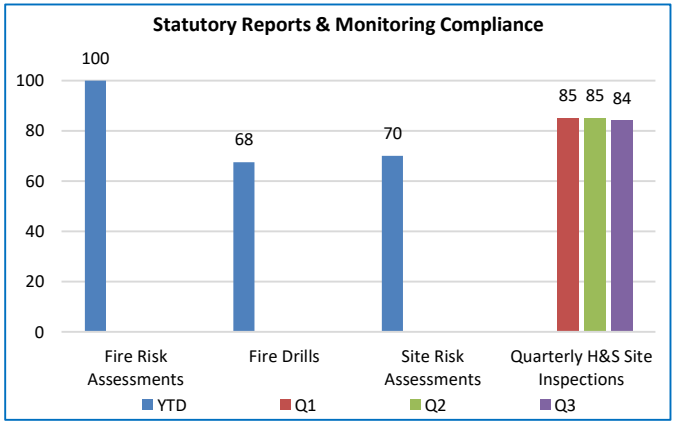
Reporting Time Lag

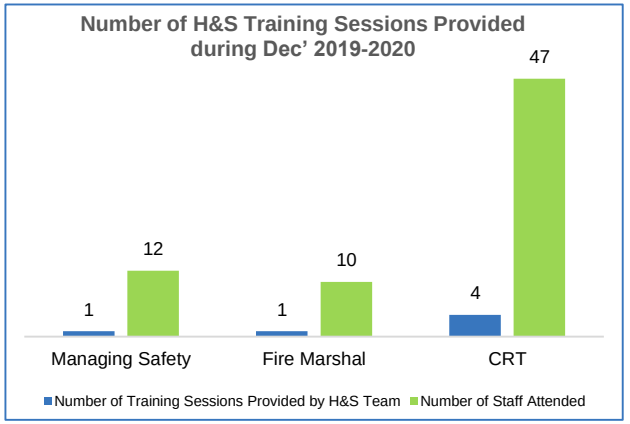


Owner: Edmund Jacobs | Exec Lead: Dr Trisha Bain

Quality Directorate





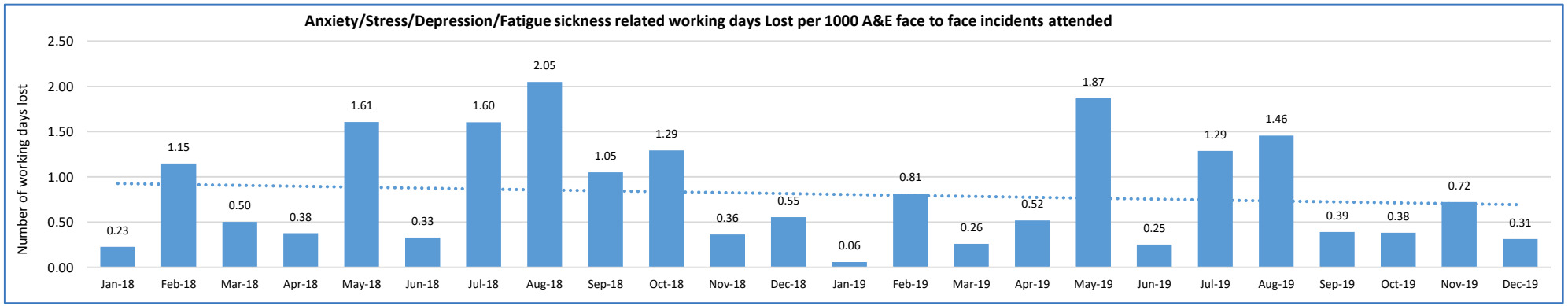


Key Updates:

1) During December'19 Health, Safety and Security department have delivered 1 session of Managing Safety courses to 12 Managers, 4 sessions of CRT to 47 staff members and 1 sessions of Fire Marshal to 10 staff members.

2) 2) The Trust wide Fire Drills (Bi-annual) compliance is currently at 68%. 3) The Trust's health and safety mandatory training compliance rate in December 2019 is 92.39%.

People & Organisational Development



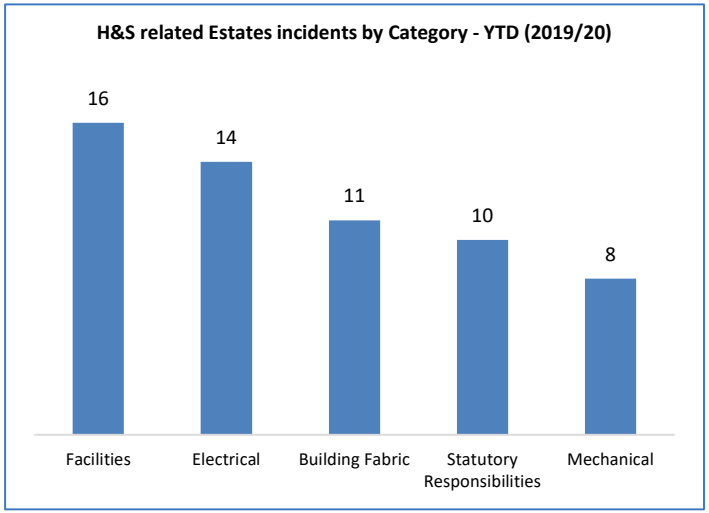
Year	Anxiety/Depression/Stress/Fatigue – Working Days Lost
2017/18	904
2018/19	977
2019/20 (up to end Dec'19)	708

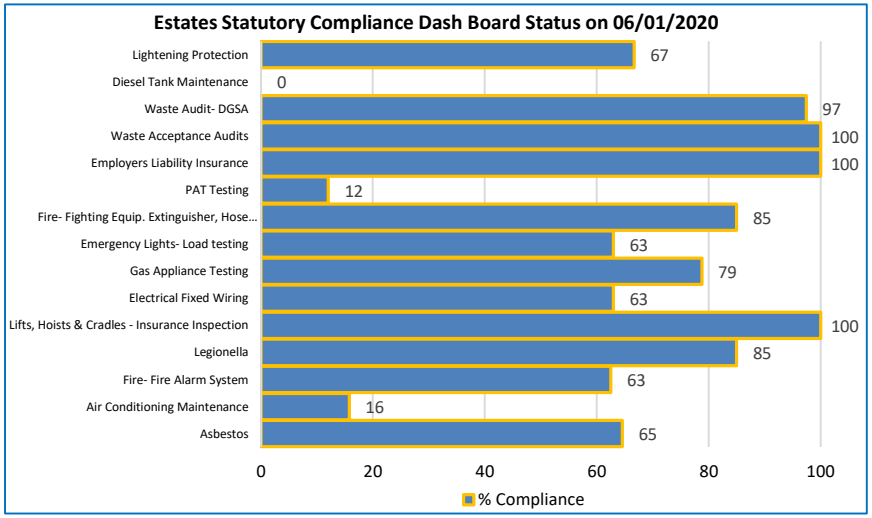
Key Updates:

The number of working days lost through Anxiety, Stress, Depression and other Psychiatric Illness are provided in the dash-board above. The sickness rate in December'19 was 0.31 (less than half a day lost per every 1000 face to face incidents we attend) which is under our Trust-wide target of <1 day.

Owner: Edmund Jacobs | Exec Lead: Dr Trisha Bain

Estates

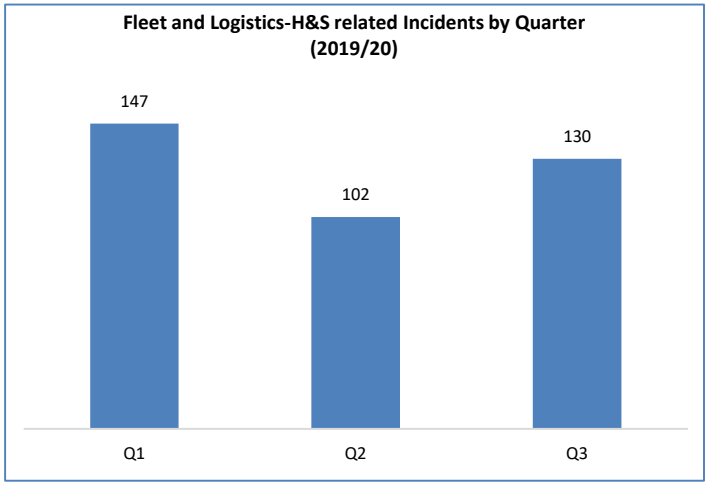


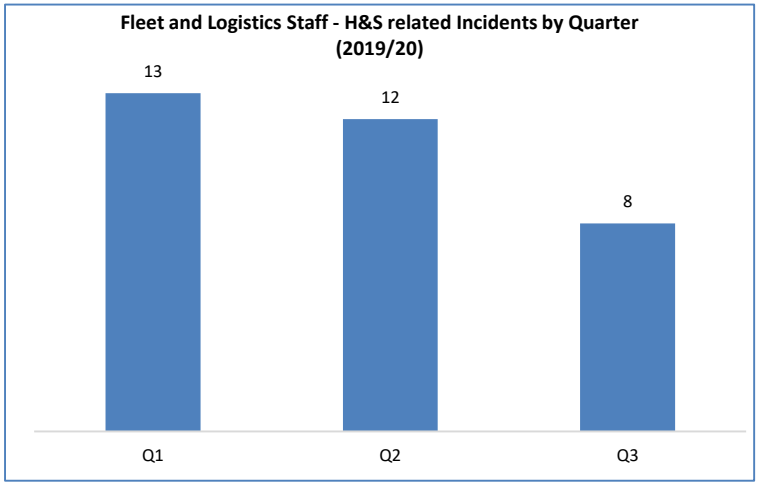


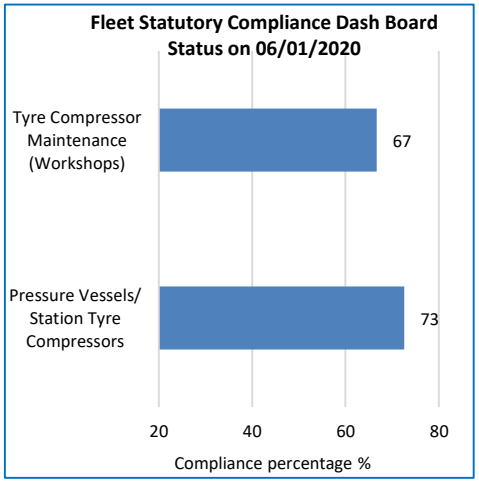
Key Updates:

- Total of 59 (H&S) Estates related incidents reported during 2019/20 (up to end of December'19). The breakdown of incidents are given in the dash board.
- Statutory compliance dash board from the Estates provides the current Trust-wide Estates related Statutory compliance rates.

Fleet and Logistics







Key Updates:

- Total of 379 (H&S) Fleet & Logistics related incidents reported during 2019/20 (up to end of December'19). Total of 33 Fleet & Logistics staff related H&S incidents reported 2019/20 (up to end of December'19). The breakdown of incidents are given in the dash board. Statutory compliance dash board from the Fleet & Logistics provides the current Trust-wide F&L related compliance rates.

Owner: Edmund Jacobs | Exec Lead: Dr Trisha Bain

MSK Incidents Report– Findings & Actions - 2019/20 (up to end of December'19)

Findings

- The South East Sector (674 WDL from 56 episodes) and North East sector (610 WDL from 48 episodes) have the highest working days lost from all areas of the trust.
- Riddor incidents have remained fairly static since April 2019 with an average of 9 per month. The highest number of Riddor incidents for November occurred either in the patients home or in a public place.
- In the month of December there is increase in the equipment handling category mainly due to the introduction of the new primary response bag and staffs lack of familiarisation.
- The peak of reporting varies by month from sector to sector with the highest reporting during April 2019.
- There is an average of 1 reported moving and handling incident for every 2000 face to face attendances and an average of 3 working days lost per 1000 attendances.
- There have been 241 episodes of absence year to date, with 211 staff having one episode of absence and 15 staff having 2 episodes.

Actions

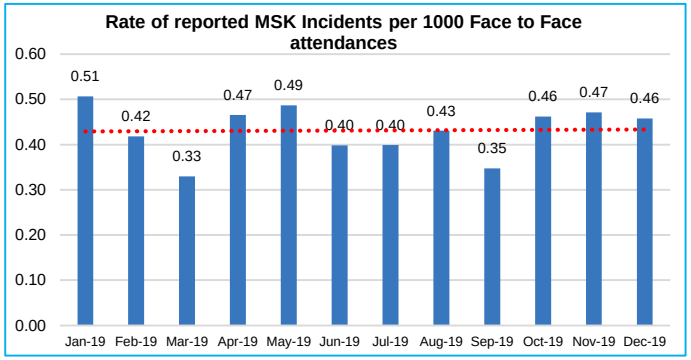
- The Datix categories and sub categories changed from 1st November with the majority of incidents being coded correctly, the department continues to monitor MSK incidents for accuracy of data and coding.
- A moving and handling poster campaign began in October 2019, these posters display facts and figures in regards to incident rates for the LAS along with hints and tips.
- An MSK action plan has been drawn up and shared with the Corporate Health, Safety and Security Committee, this covers all areas of the Trust, this is due to be converted into a QSIR project plan.
- Due to the increase in failures of Mangar Elk a task/finish group has been set up to identify root causes and remedial actions, we have also met with the manufacturer to improve the servicing and turnaround times going forward. Short video clips and stickers along with bulletins are to be produced around the use of the Mangar Elk to try and address some of the root causes of failure.

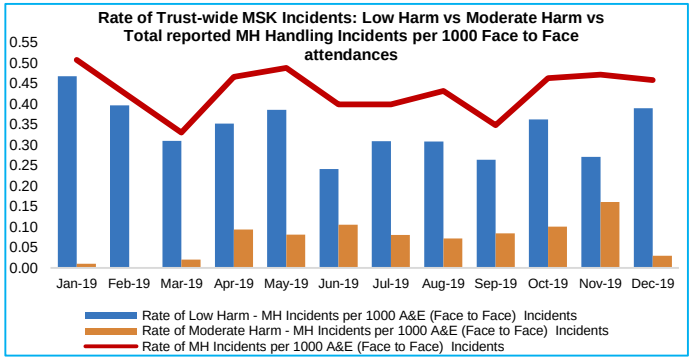
General

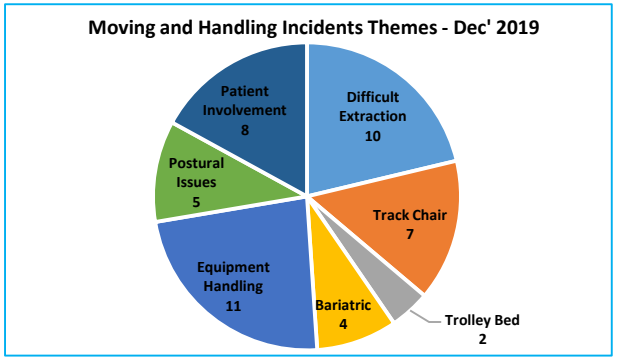
- In December representatives from the Trust will be attended a Symposium run by the Association of Ambulance Chief Executives in collaboration with Manchester University and the Health & Safety Executive to cover Prevention, Control to Reduce Risks and Supporting Staff in relation to Moving and Handling. Workshops were undertaken with other ambulance trusts in order to identify best practice and joined up thinking in order to improve all Ambulance Trusts approach to moving and handling and consider a national approach the ongoing issues surrounding MSK absence and incidents.
- The Health, Safety & Security Managers now have access to the Legal module of Datix and this will help with bringing together learning points and actions from both PI claims and incidents.
- Through the use of Datix we are able to identify trends in failure of equipment or unsafe practices, the Manual Handling Steering group review this data and ensure that staff have the right tools to manage moving and handling of patients in a controlled and assessed way.

Owner: Edmund Jacobs | Exec Lead: Dr Trisha Bain

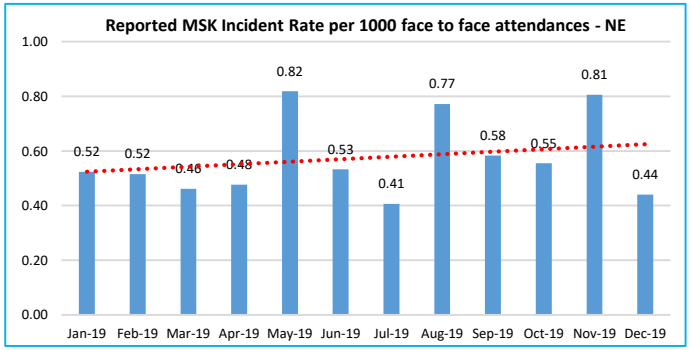
Mandatory & Statutory Compliance & Manual Handling (MSK) related Incident, Sickness and Severity Rates

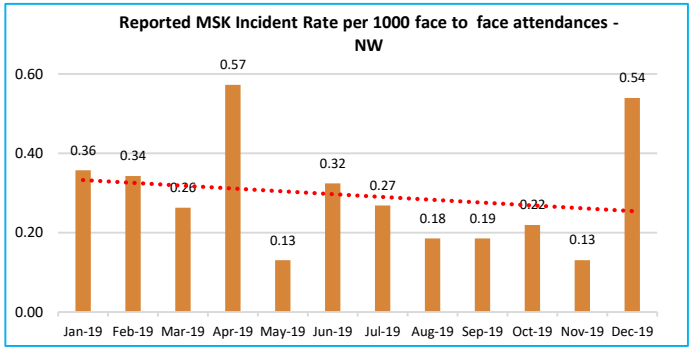






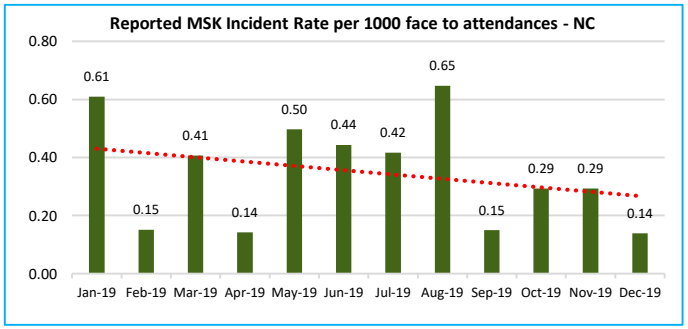
The graph above (first) provides the Rate of reported MSK incidents per 1000 face to face Attendances. According to the number of reported incidents, approximately one MSK incident occurred per every 2000 face to face attendances. The graph above (second) provides the Severity rate of reported MSK incidents per 1000 face to face Attendances.

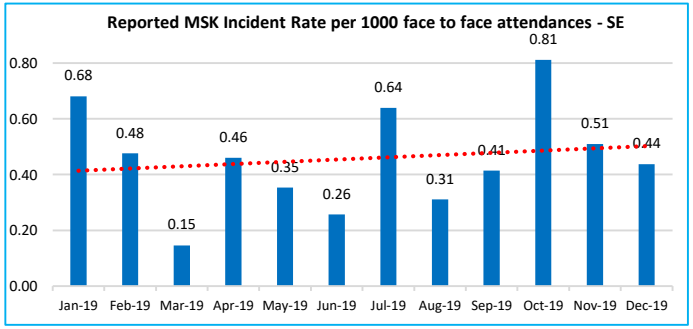


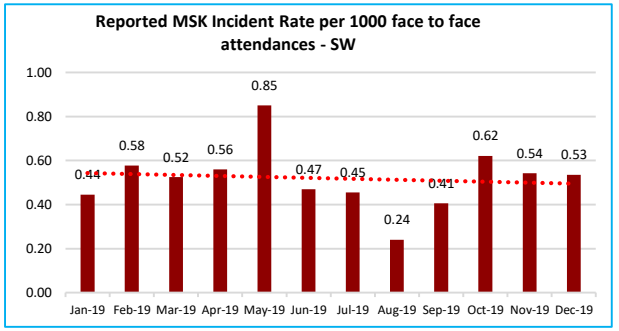


Above Pie-Chart Provides:

- 10 of the incidents relate to a difficult extraction of the patient from their property, such as space constraints, awkward stairs etc.
- 11 of the incidents involved equipment handling, some of these relate to the new primary response bag along with not having working equipment or the availability of equipment
- 8 of the incidents are related to where patients have moved or been non compliant whilst staff have been assisting them.
- 7 of the incidents involving using the trach chair, these occur sometimes when the patient is non-compliant or grab out when unbalanced.

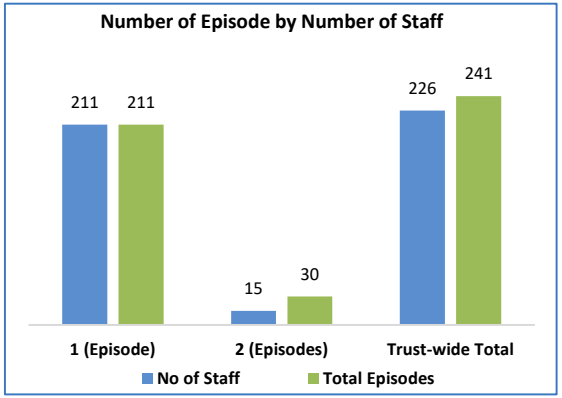


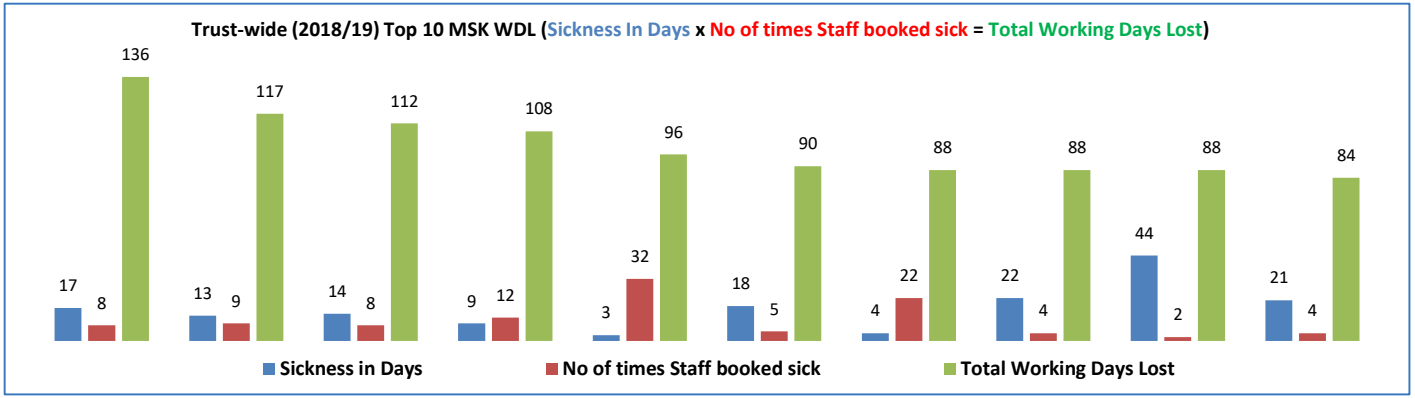




The graphs above provides the Rate of reported MSK incidents per 1000 face to face Attendances by sectors. According to the number of reported MSK incidents approximately one MSK incident occurred per every 2000 face to face attendances across each sectors.

Analysis of MSK Sickness Working Days Lost (WDL) during 2019/20 (up to end of Dec'19) by Station & by Sector



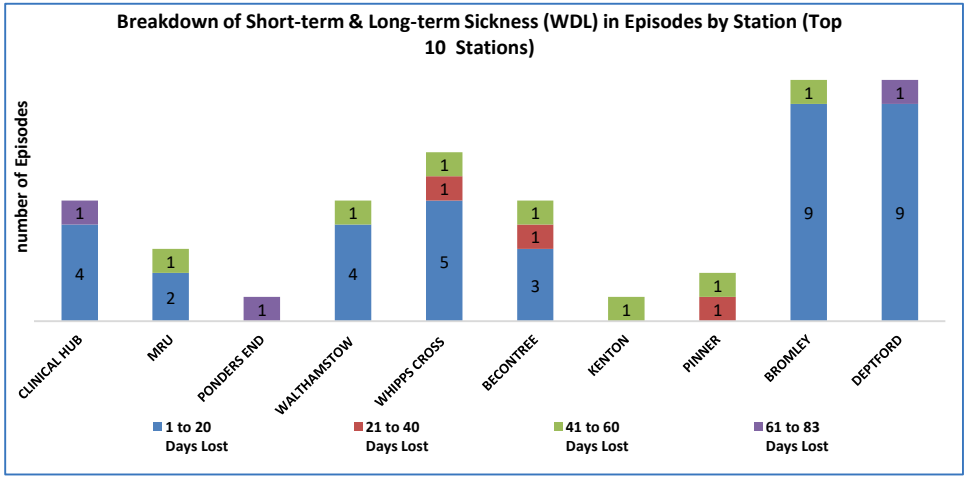


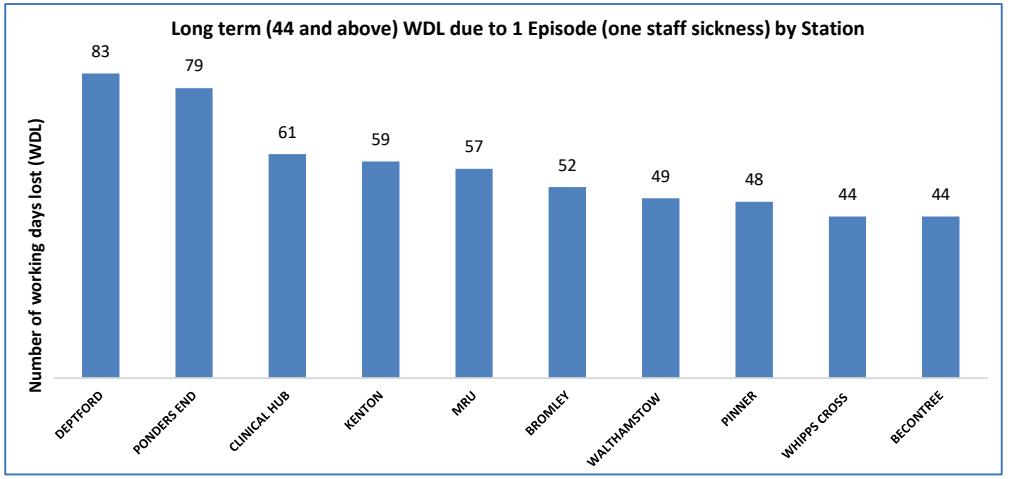
A total of 226 staff members booked off sick due to MSK injury during 2019/20 (up to end of Dec'19). 211 staff out of the 226 have booked sick once and the remaining 15 staff have booked sick twice which totals to 226 episodes of sickness.

The graph above provides the top 10 WDL during 2019/20 (up to end of Dec'19) in terms of the number of days staff booked off sick and the number of times (episodes) booked.

Analysis identifies:

- 17 days sickness from 8 episodes accounted for 136 working days lost.
- **3 days MSK related sickness was most frequent length of time staff took away from work, followed by 4 days sickness across the Trust**.





- The graph above (left) provides the top 10 Stations, short term and long term sickness working days lost (WDL) by number of episodes.
- 1 to 20 days sickness booked 36 times & 21 to 40 days sickness booked 3 times, 41 to 60 days sickness booked 7 times, and 61 to 83 days sickness booked 3 times across the Trust.
- 83 working days lost was the highest WDL by an single episode of sickness booked which was from Deptford station.
- The graph above (right) provides the Long term sickness (44 and above) WDL due to 1 Episode (one staff sickness) by Station.

Owner: Edmund Jacobs | Exec Lead: Dr Trisha Bain

Violence & Aggression Incidents (Physical Assaults on Staff) Report– Findings & Actions - 2019/20 (up to end December'19)

Findings

- The North West Sector has reported the greatest number of physical assaults (year to date) while the South West Sector has the highest rate of physical assaults per 1000 face to face attendances (year to date);
- The greatest number of reported physical assaults (55%) occur due to the clinical condition of the patient;
- Police attended 60% of physical assault incidents;
- 6 successful prosecutions for assault have been recorded (year to date);
- 1 Assault resulted in an HSE specified injury which is the subject of an HSE enquiry.
- Obtaining notifications of all prosecutions has proved difficult, especially so if the police investigation is protracted and there is an extended period of time between the incident and any court hearing.
- Feedback from CQC report found security of sites and vehicles was not effective.

Actions

- Trust has agreed for a centrally funded trial of body worn video to address violence and aggression to be carried out this financial year, as one of a number of ways it will seek to reduce assaults;
- Conflict Resolution Training (CRT) videos have been shot in/around ambulance and now going through editing process to be loaded onto the Pulse;
- VRC have agreed to provide a 'shell' ambulance with trolley bed and attendant's chairs for CRT sessions;
- CRT training to be informed by reported incidents;
- An awareness campaign around violence and aggression to be agreed with LAS Comms team;
- Health, Safety & Security team to undertake 'dip sample' audits of reported violence and aggression incidents to monitor outcomes and support at a local level;
- Health, Safety & Security team to monitor incidents that have potential of a prosecution and liaising with the victim and manager.
- Health, Safety & Security team to undertake security mystery shopper visits to all sites, following findings from CQC report.

General

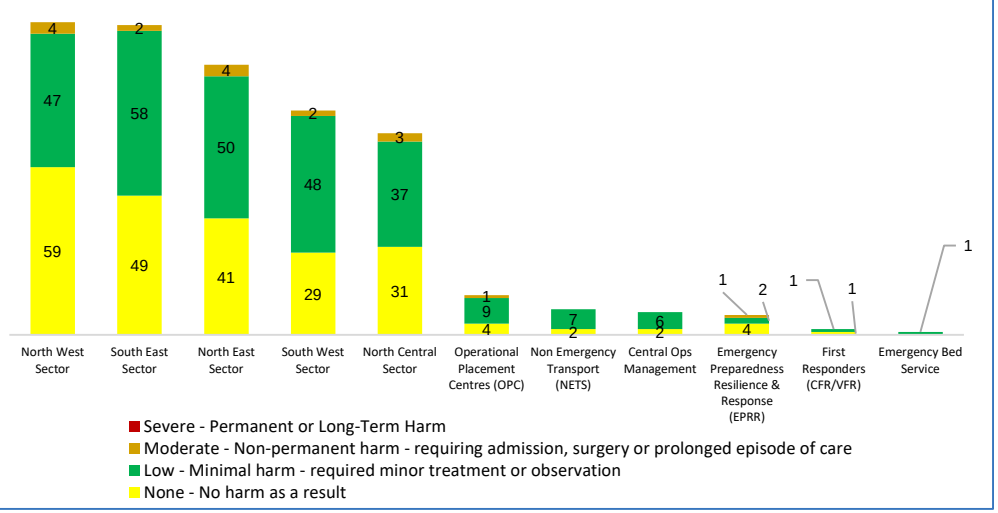
- It is proposed that any Datix incident that is subject to an external investigation, such as a police criminal investigation, should remain open until the result of that investigation is known (eg, a successful prosecution with sentence details).
- Health, Safety & Security team have access to the CAD log so that Metropolitan Police CAD numbers associated with LAS CADs can be identified and any related Crime Reference Number can be obtained from the police and its progress logged on a prosecution tracker.
- Category to identify attendance at hospital by victim to be added to Datix.
- Following the reporting of any severe related violence and aggression incident, Datix will trigger a notification to the Chief Executive and Chief Operating Officer, who will contact the victim by letter or phone call.
- Closer cooperation with police being sought in following up assault incidents through Blue Light Collaboration work and the Metropolitan Police's *Operation Hampshire* dealing with prosecutions under the Assaults on Emergency Workers (Offences) Act 2018.
- Working with the Metropolitan Police's lead for Operation Hampshire dealing with prosecutions under the Assaults on Emergency Workers (Offences) Act 2018 to follow up staff assaults reported to the police, following meeting held in December.

Latest Updates

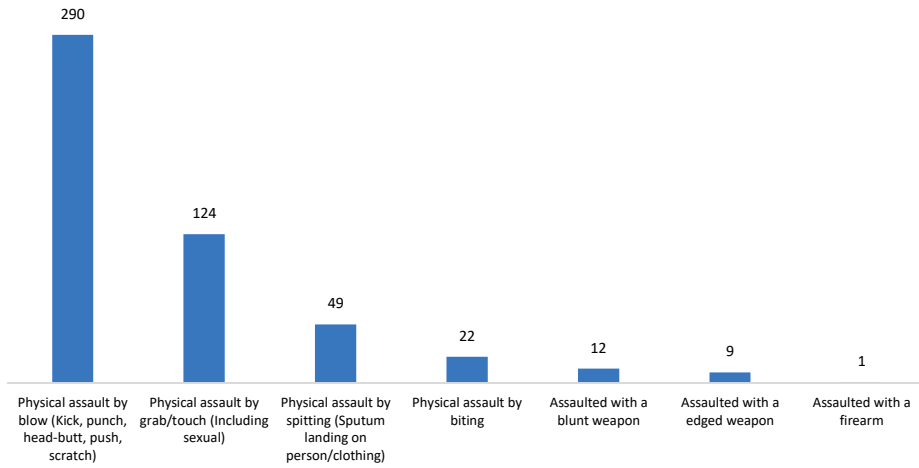
- BWVC trial funding advised by NHS England / Improvement (NHSE/I) at £190,000. Memorandum of Understanding relating to the funding to be agreed between NHSE/I and LAS.
- Meeting with Metropolitan Police (MPS) lead for BWVC taken place who will attend project group meeting in early January to present the MPS BWVC operational system and management.
- LAS liaising with NEAS and NWAS.

Physical Assaults on Staff Incidents – 2019/20 (up to end December'19)

Number of reported Physical Assaults on Staff by Sector & Severity (YTD) –2019/20



Number of reported Physical Assaults on Staff by Type (YTD) – 2019/20



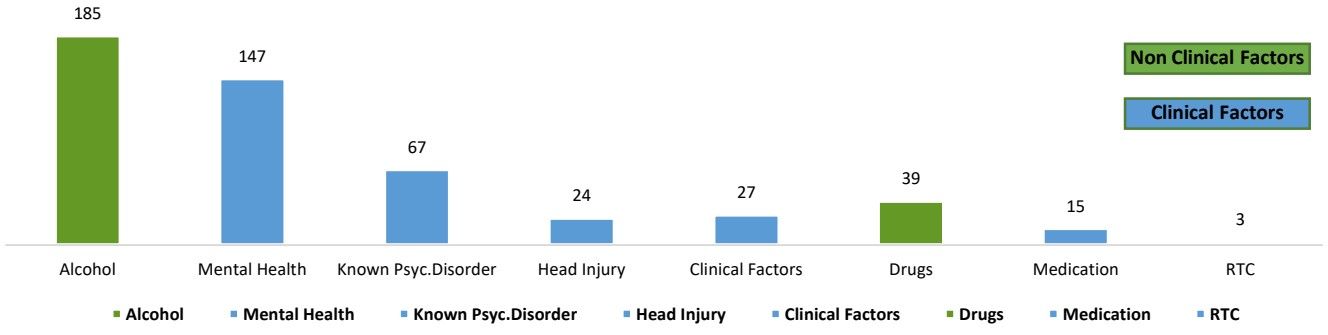
Notes:

- **A total of 507 Physical Assaults on Staff were reported during 2019/20 (up to end Dec'19).**
- **224 (44%) of the incidents were reported as 'No Harm/Near Miss incidents, whilst 283 incidents resulted in Harm. 266 (52%) of the harm related incidents were reported as 'Low Harm and 17 (4%) incidents were reported as Moderate Harm.**
- **25 out of the 507 Physical Assaults on Staff were caused by others (ex: family member of the patient / by standers etc).**

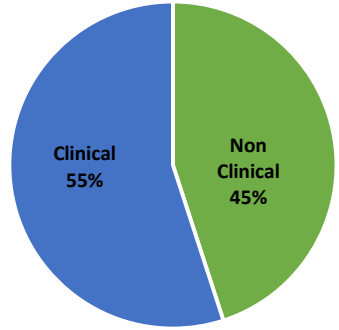
Notes:

- **Physical Assault – by blows, kicks/ assault to staff (57% , n=290) accounted for the highest number of incidents reported during 2019/20 (up to end Dec'19).**

Number of reported Physical Assaults on Staff by Influencing Factors (YTD) – 2019/20



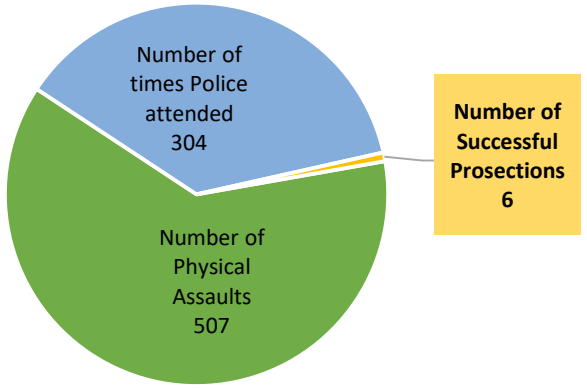
Percentage Breakdown of Factors (YTD) – 2019/20



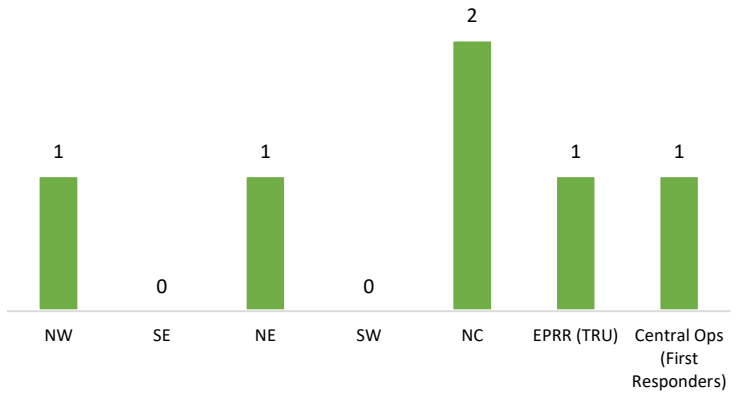
Notes:

- **CLINICAL Factor: 280 (55%) of the incidents occurred due to Clinical Factors, such as Mental Health (n=147), Known Psyc.Disorder (n=67), Head Injury (n=24), Clinical Factors (n=27), Medication (n=15).**
- **Non Clinical Factor: 227 (45%) of the incidents occurred due to Non Clinical Factors, such as Alcohol (n=185), and Drug (n=39) and, RTC (n=3).**

Number of: Physical Assaults - Police Attended - Successful Prosecutions (YTD) – 2019/20



Number of Successful Prosecutions (YTD) – 2019/20



Notes:

- Total of 507 physical assaults on staff reported during 2019/20 (up to end Dec'19).
- Police were attended 304 occasions out of the 507 incidents.
- 6 cases were successfully prosecuted during 2019/20 and the outcome of the prosecution are given in the dash-board below.

Datix ID	Security Incidents - Prosecution Outcomes (YTD)	Assault Type	Sector
31139	Offence of Assault by beating of an emergency worker, the defendant was required to pay compensation of £100.00, the defendant was required to pay costs of £85.00 to the Crown Prosecution Service.	Physical & Threatening / Verbal / Harassment	Central Operations (First Responders)
31327	Defendant was imprisoned for 45 days.	Threatening/ Verbal Abuse	North East
33372	12 month community order 120 hours of unpaid work £85 in court cost	Physical - Spat	North West
29885	Compensation £100.00 Fine £625	Physical Assault	North Central
28840	Assault by Beating of an Emergency Worker – 24 weeks imprisonment (concurrent with below). Racially Aggravated Common Assault/Beating – 30 weeks imprisonment and £250 compensation.	Physical Assault	EPRR (TRU)
35457	Offence of Common Assault on Emergency worker, the defendant was required to pay Fine of £300, compensation of £100.00, costs of £85.00 to the Crown Prosecution Service and Surcharge to fund services of £32.	Physical Assault	North Central

Claims:
Currently there is no claim made by staff member due to physical assault.

Trauma Risk Management (TRiM):
TRiM referrals related to violence and aggression: 01/04/19 to 30/09/19 = 27; 01/10/19 to 31/10/19 = 7

Owner: Edmund Jacobs | Exec Lead: Dr Trisha Bain

Body Worn Video Cameras (BWVC)

The LAS Exco have agreed for a trial of BWVCs to be undertaken and commence this financial year. NHS England / Improvement has advised a funding settlement of £190,000 for the LAS to trial Body Worn Video Cameras (BWVC) as part of phase 1 of the National trial of BWVC to commence this financial year (2019/2020).

- **Body Worn Video Cameras (BWVC)**: small cameras worn on the body by frontline staff, to record visual (and often audio) interaction between public and wearer. Saved footage is encrypted securely on the device can be downloaded and stored securely and may then be used as evidence in criminal prosecutions. BWVC are primarily seen as a form of 'personal protective equipment'. These devices are believed to help reduce the impact of violence against staff. The trial is intended to evaluate their effectiveness in doing so
- Funding is being made available centrally for the trial to take place, although it is yet to be released and the final funding amount for each Trust is to be confirmed. However, as part of the first phase, NHS England / Improvement has indicated a funding settlement of circa £175,000 for the LAS to trial BWVC for 12 months, the first phase commencing this financial year (2019/20). This funding should cover the costs of procuring cameras, docking stations, cloud storage and electronic issuing system. Part of the funding may be used to contribute to the cost of dedicated project support, including IT support.
- All Trusts in the first phase will be required to use a commercial framework agreement to procure BWV units. One such current framework available to use is from the East Midlands Strategic Commercial Unit, which incorporates nine suppliers who all meet prescribed standardisation. Discussions are also taking place with the Metropolitan Police to explore the possibility of using their supply contract agreement.
- The LAS would be expected to bear the costs of funding BWVC for subsequent years following the first year, if the trial is successful and the LAS agree to take forward the provision of BWVC for staff. These costs would include any further BWV units required and all ongoing storage
- A successful trial of body worn cameras at the LAS will evidence a reduction in the levels of violence and aggression experienced by staff, together with an increased level of successful prosecution, enabling the risk (678) to be reduced from 9; significant, to its target rating of 6; moderate.

<u>The potential benefits of a reduction in violence and aggression include:</u>

- Improved staff morale due to investment of cameras to protect their Health and Safety;
- Improved and seamless evidence gathering in circumstances where Police involvement is required;
- A decrease in the time taken to provide sufficient evidence to support a prosecution;
- An increase in the number of successful prosecutions;
- Improved Staff Survey results;
- Improved Staff engagement, motivation and security as a direct result from investing in staff health, safety and wellbeing;
- Increased Patient Care, patient experience and patient engagement;
- Reduction in the risk of violence and aggression towards staff from an improved level of care provided to staff under Health and Safety duty of care;
- Reduction in staff sickness levels resulting from violence and aggression incidents;
- Reduced pressure on resources from fewer crews being taken off the road following violence and aggression incidents.
- Enhanced relationships with stakeholders, including staff-side;
- Mitigation to reputational damage related to assaults experienced by LAS staff.

North East Ambulance Service (NEAS) undertook a small scale pilot funded by a provider October 2018 – January 2019. They are now part of the first phase of the centrally funded 12 month National Trial with North West Ambulance Service (NWAS) and LAS. NEAS have provided feedback on their trial which is being used to inform the LAS trial. The LAS is liaising closely with both NEAS and NWAS.

A project group is being formed to initiate and manage the LAS trial. The project group will identify suitable stations from which to run the trial using physical and non-physical assault data. There will be a wide representation of stakeholders on the project group. This will include, among others: Staff Side, who have indicated their engagement with this process ; IM&T; and the LAS Comms team to help plan and support an effective engagement campaign with stakeholders (staff, patients and partner agencies), which will help allay patient and staff concerns around filming. NEAS's experience with these issues will help inform the campaign.

Owner: Nicola Bullen | Exec Lead: Dr Fenella Wrigley

Key milestones and deliverables

Q1: Planning

Contact supplier and ensure sufficient vaccine can be delivered within required timeframes

Confirm vaccine ordering volumes with medical directorate

Confirm staff groups to be included in CQUIN count

Confirm rationale for the groups to be excluded

Initial meeting with comms to develop promotional activity

Confirm incentives with ADO's/ Medical Directorates

Identify administration resources to deliver Flu programme

Review lessons learned from previous years

Review number of vaccinators available

Discuss incentive ordering with Procurement

Develop implementation plan

Quarterly progress report

Q2: Preparation

Contact all available vaccinators to advise them of start dates

If applicable (based on review) train more vaccinators

Develop a Patient Group Direction (PGD) which is a written instruction for the sale, supply and/or administration of medicines to groups of patients who may not be individually identified before presentation for treatment set up ready to sign for vaccinators (Medical Directorate to Lead)

Ensure fridges fully functional across all sectors

Communications plan approved Medical Directorate

Start communication (as per plan) of dates and opportunities (end of Q2)

Review and explore all opportunities for engaging front line staff – for example; roadshows, managers briefings, RIB, Facebook

Refresh online solutions for staff to update their record (i.e. those staff who had their vaccination from GP or alternative provider)

Prepare schedule for vaccination programme

Start vaccination programme (anticipated Mid October)

Consider activity recording to enable submission of cumulative data monthly over four months on the ImmForm website

Quarterly progress report

Q3: Implementation

Communication and promotional articles – for example, photo and editorial of Executive members having their vaccinations

Ensure use of all LAS communication channels to raise programme profile i.e. advertise dates and options for our staff

Monitor and review uptake rate, ensure enough on-going dates are scheduled

Tailor communication depending on numbers of staff vaccinated per week

If required set up vaccinators to be available for large team meetings in addition to specific dates

Quarterly progress report

Q4 Evaluation

Continue to offer vaccinations and monitor numbers

Review of final uptake

Provide final progress report to include evaluation and lessons learned

Owner: Eva Bartoskova| Exec Lead: Dr Fenella Wrigley

Key milestones and deliverables

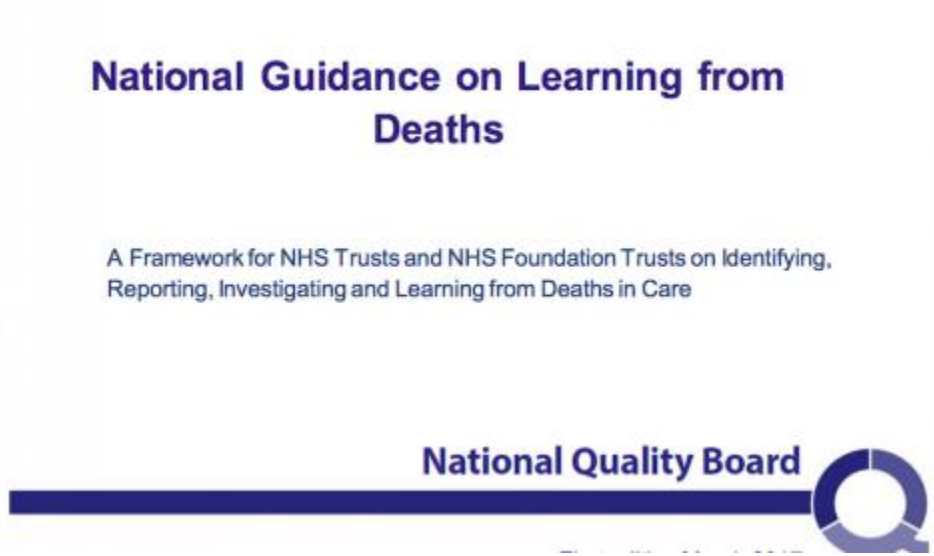
Learning From Deaths (LFD) policy has been submitted to the Trust board on the 1st December 2019 (as recommended by the NHSI LFD guidance document)

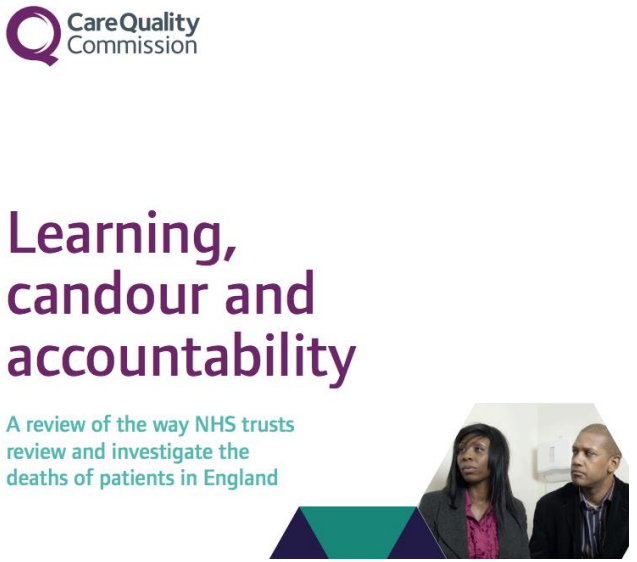
7th January 2020 the Trust leads for LFD have undergone initial training on Structured Judgement Review (SJR) process which is imperative to the clinical review aspect of the LFD process. This is in order to start the actual reviews of clinical cases.

We are currently in process of finalising our Standard Operating Procedure (SOP) for implementing SJR into clinical reviews.

We have progressed with our LFD electronic database into its final stages and will start testing it in February.

The view is to start undertaking LFD reviews for Q4 of 2019 with the first data available at the end of Q1 2020.





2. Effective

To be effective we must ensure that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence. Our overall performance in this area over the past month is summarised by our Trust-wide Scorecard.

For further assurance we then provide additional data and analysis on:

- Clinical Ambulance Quality Indicators
- Clinical Audit Performance

Outstanding Characteristic: *Outcomes for people who use services are consistently better than expected when compared with other similar services.*

Trust-Wide Scorecard

Exec Lead: Dr. Fenella Wrigley

Measures	Target / Range	RAG	YTD 19/20	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
ROSC at Hospital (AQI)	30%	G	34%	36%	31%					↔			LQ1a		
ROSC at Hospital UTSTEIN (AQI)	55%	G	60%	62%	63%					↔			LQ1b		
STEMI care bundle (AQI) (Reported every 4 months)	74%									↔			LQ2c		
Stroke Care Bundle (AQI) (Reported every 4 months)	98%		98%							↔			LQ3b		
Stroke on scene time (CARU continual audit)	00:30	G	31	31	31	31	31	0		↓					
Survival to Discharge (AQI)			9%	9%	8%					↓					
Survival to Discharge UTSTEIN (AQI)			28%	20%	30%					↓					
STEMI- On scene duration (CARU continual audit)			39	38	39	38	39	0		↓					
Call to Angiography - Mean (hh:mm)			02:09	02:09	02:10										
Stroke - Call to Arrival at Hospital - Mean (hh:mm)			01:10	01:13	01:05										
CPI - Completion Rate (% of CPI audits undertaken)	95%	R	90%	93%	88%	87%	92%	92%		↑		✓	LQ12	✓	
CPI - Percentage of Staff receiving two feedback sessions YTD			7%	3%	5%	9%	15%	22%		↑			LQ12		
Documented Care - Cardiac Arrest Compliance (CPI audit)	95%	G	98%	98%	97%	98%	97%	98%		↑		✓	LQ12		
Documented Care - Discharged at Scene Compliance (CPI audit)	95%	R	97%	98%	97%	94%	93%	94%		↑		✓	LQ12		
Documented Care - Mental Health Compliance (CPI audit)	95%	R	95%	95%	95%	94%	95%	94%		↓		✓	LQ12		
Documented Care - Severe Sepsis Compliance (CPI audit)	95%	G	97%	97%	97%	95%	96%	96%		↓		✓	LQ12		
Documented Care - Difficulty In Breathing Compliance (CPI audit)	95%		96%		96%		95%			↓		✓	LQ12		
Documented Care - Elderly Falls Compliance (CPI audit)	95%	R	94%	94%	95%	94%	93%	94%							
Documented Care - Glycaemic Emergencies Compliance (CPI audit)	95%	R		98%						↔			LQ12		

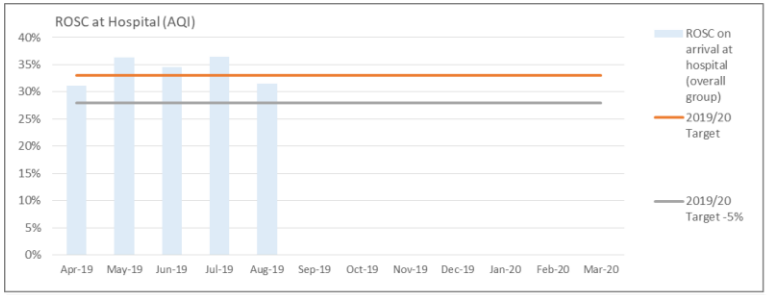
Clinical Performance Indicators

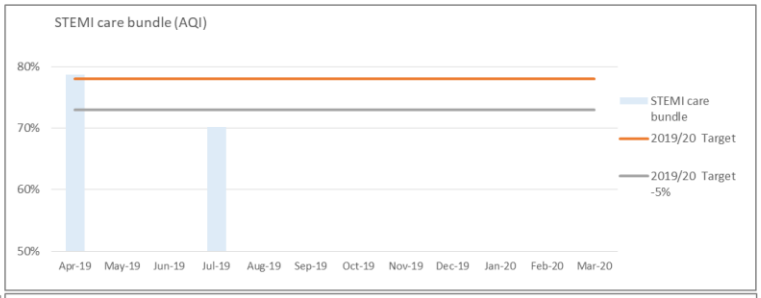
In December, CPI training was delivered to 12 academy student paramedics, 12 paramedics on restricted duties, 6 members of OPC staff, 2 APPs and 1 EMT for their information. The recruitment of CTMs will address the CPI performance.

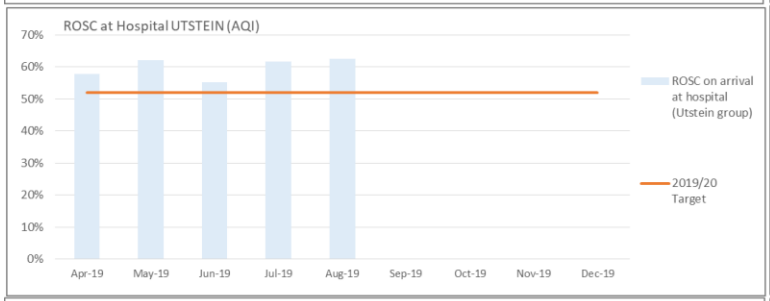
CPI auditors reported 8 potential incidents via Datix and contacted EBS to discuss the potential for 1 retrospective safeguarding referral.

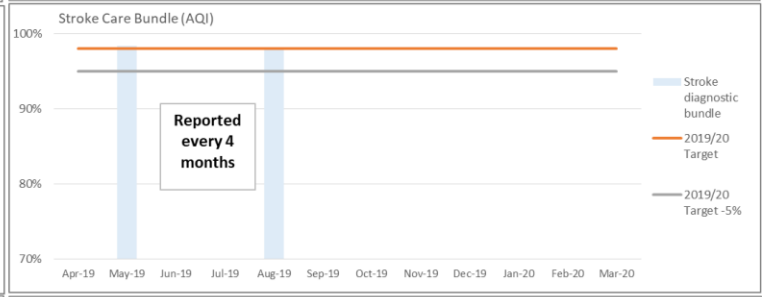
Clinical AQIs

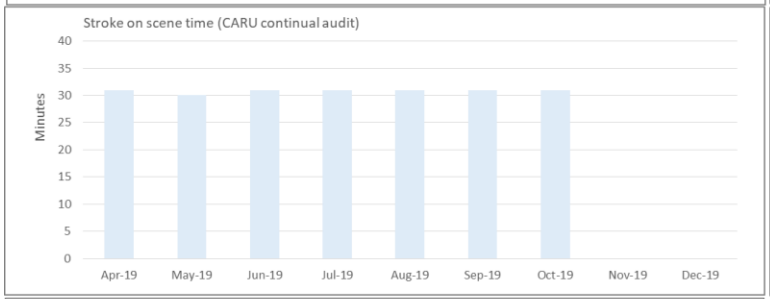
Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley

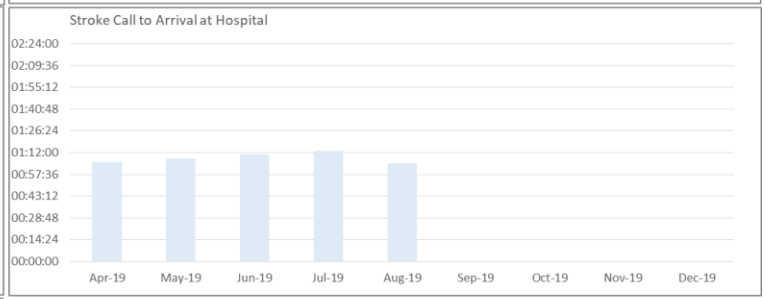


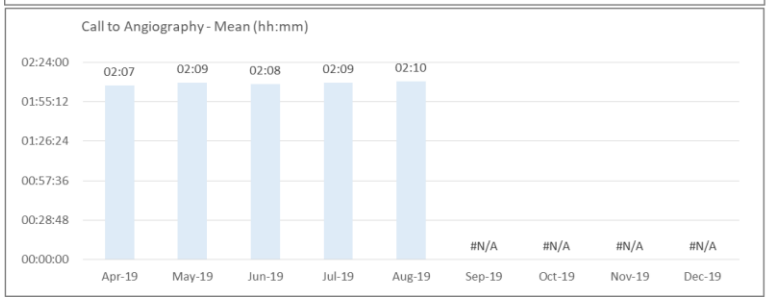






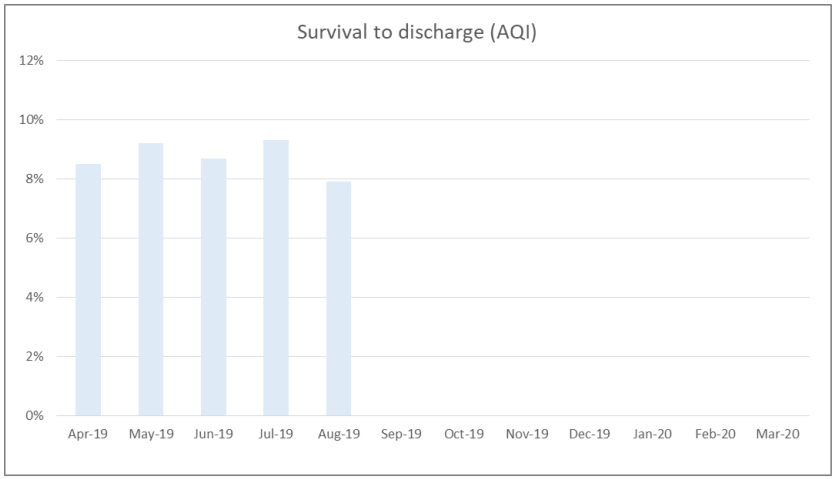


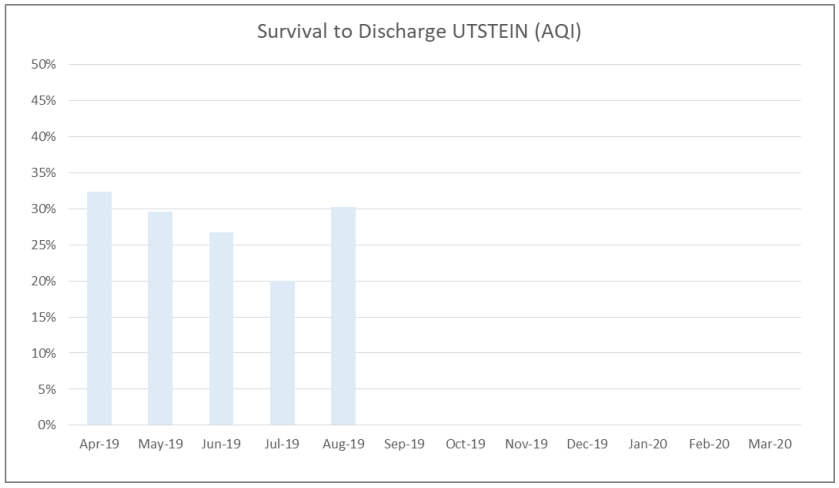




Clinical AQIs

Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley





AQI: Narrative

Cardiac arrest: As with previous months, our rates of ROSC for cardiac arrest patients were above the national average for both the overall (31.4%) and Utstein (62.5%) groups however our survival to discharge remains below the national average at 7.9% of all patients and 30.2% of patients in the Utstein group.

STEMI: Our call to angiography time for STEMI patients was 02:10, slightly better than the national average of 02:11.

Stroke: The LAS ranked best in class again for the mean call to hospital for suspected stroke patients (01:05) in August, the 4th time this financial year. The stroke diagnostic bundle for August was also published this month and shows the LAS achieved compliance of 98.1%, below the national average (98.5%). The LAS has dropped from a ranking of 4th place in May to 8th in August.

Sepsis: NHS England did not publish Sepsis Care Bundle data for August, the next data due to be published will be for September (in February).

* The time lag for these measures is reflective of the time taken to receipt all the information required from NHS England

Clinical Audit Performance

Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley

Clinical Audit Update

- As a result of our Continuous Re-contact Clinical Audit, in December: 11 crews were recommended for feedback (9 constructive and 2 positive), and 3 potential incidents were reported via Datix - 2 were for unexpected death (1 is awaiting SIG review and the other was confirmed to be an expected death) and 1 for a patient severely deteriorated after being discharged at scene (this is awaiting investigation).

- In December we published an infographic highlighting the key findings and recommendations from a clinical audit examining the assessment and management of spinal injuries by the LAS.

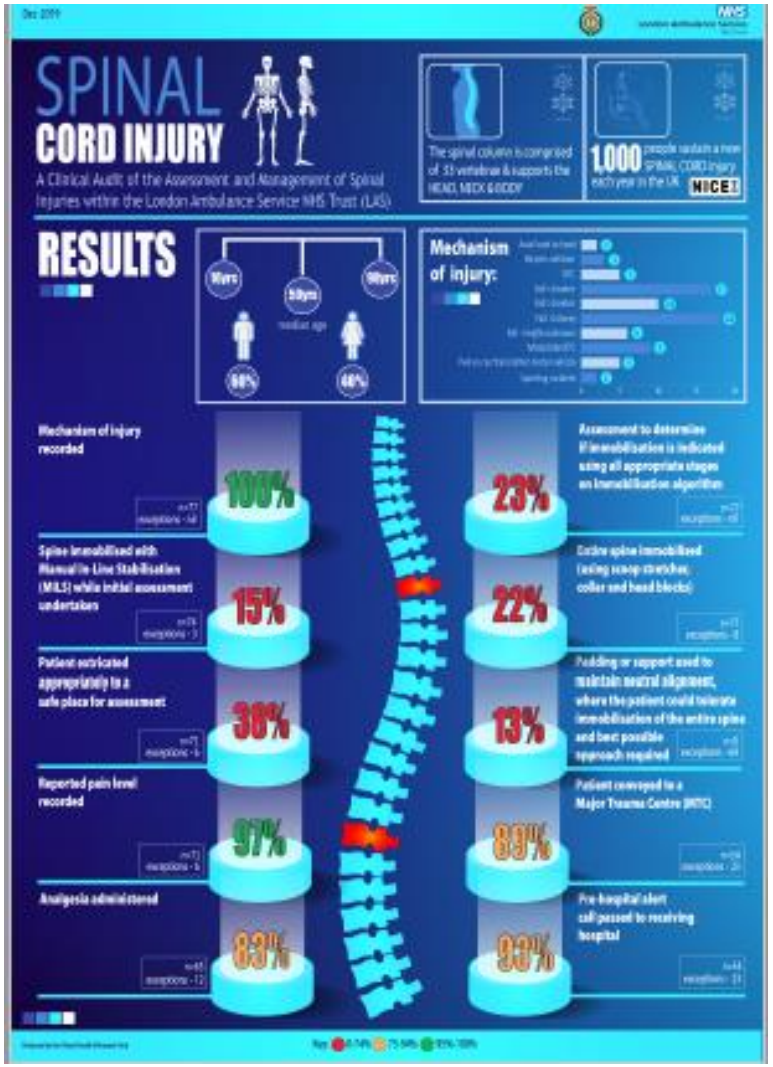
Research Update

- This month the Executive Group from our local Clinical Research Network agreed to award our Trust the requested amount (£149,841) for research activities in the next financial year. This budget will be used to support the costs associated with a growing number of portfolio projects being set-up and conducted within the LAS.

- The AIR-CGM is a study which assesses the impact of continuous glucose monitoring in Type 1 diabetes. In December, the LAS referred 11 potential participants to the study Sponsor. Since the study started in December 2018 there have been a total of 180 patients referred by the LAS. The current recruitment total for AIR-CGM is still 25 participants as no patients were recruited this month.

- ARREST is a randomised-controlled trial exploring whether immediate coronary angiography and percutaneous coronary intervention can improve survival from cardiac arrest. One paramedic completed ARREST training in December, taking the total of trained paramedics up to 519. 26 patients were recruited to the ARREST trial this month, which makes the current recruitment total 510.

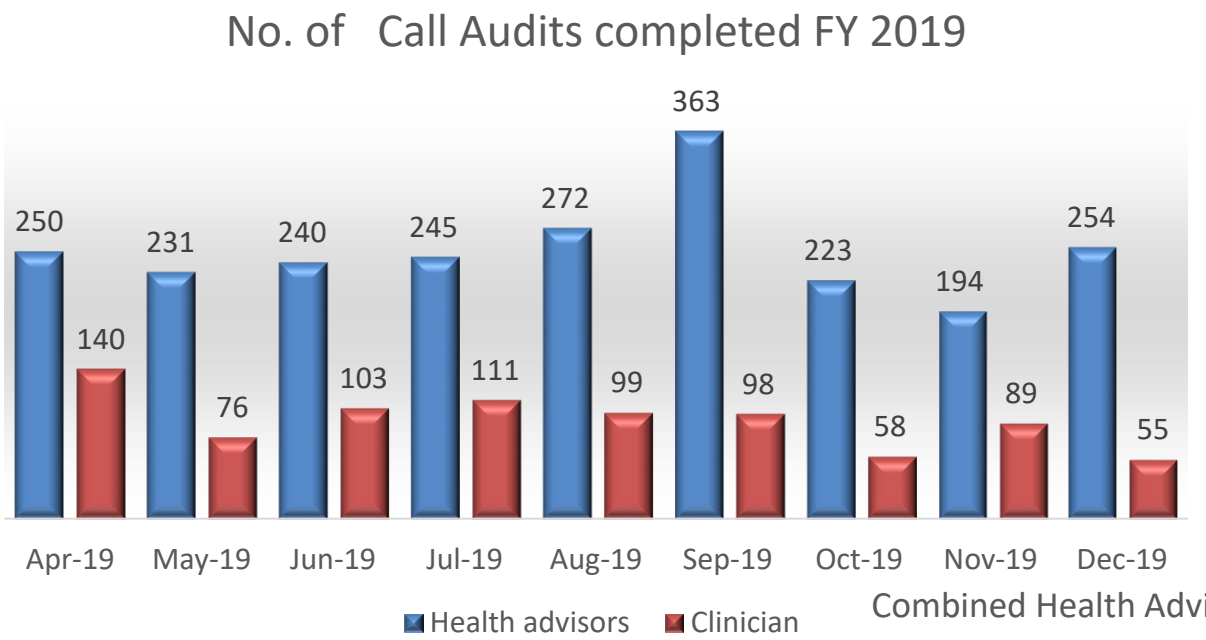
- The study investigating the identification of end of life care patients by paramedics is in its final few weeks of recruitment. The research is being conducted by the South East Coast Ambulance Service NHS Foundation Trust's Research and Development department and is funded by the College of Paramedics. It is hoped that this will contribute to improving access to end of life care for appropriate patients. In December, 20 staff completed the online survey taking the recruitment total up to 103. This exceeds the recruitment target (100 study participants) set by the study Sponsor. The online survey will be closing shortly at 23:59 on 5th Jan 2020.



Quality Audit Data December

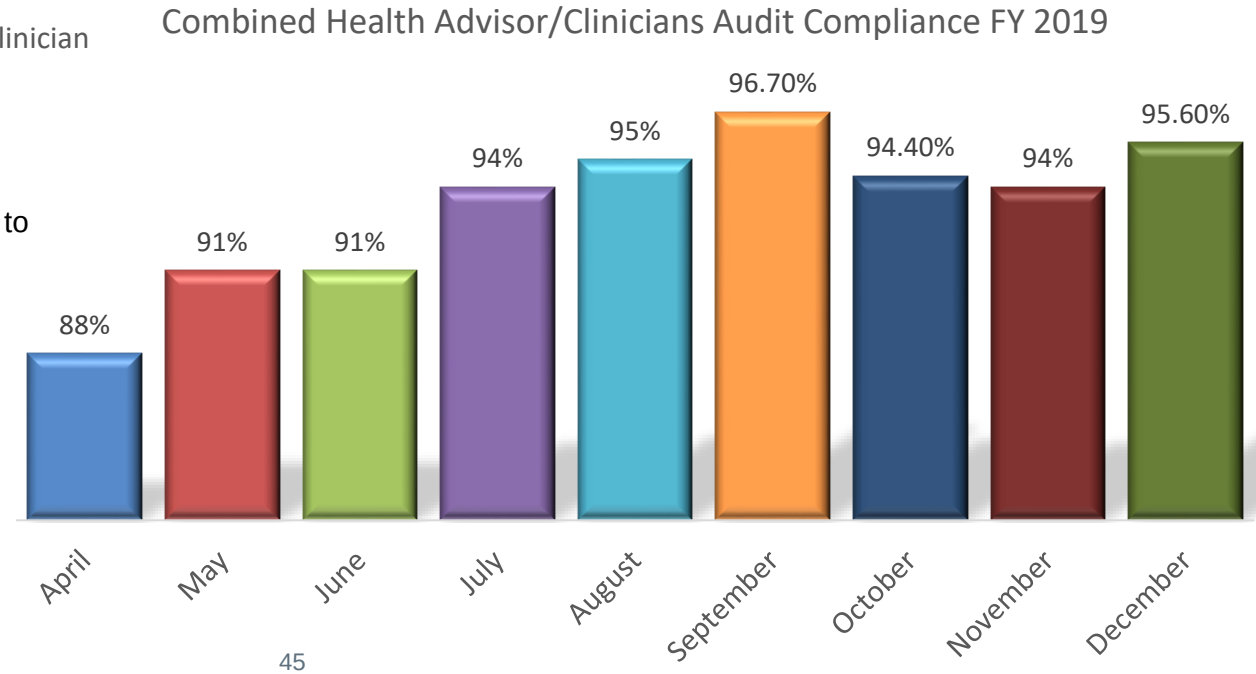
Role	Completed	Number Passed	%	Comment
Health Advisor Random Audits	290	264	91%	Audit themes worsening advice, choosing the appropriate pathway, reaching an appropriate & safe disposition and missing pathways questions. **Of the 587 audits scheduled for Health Advisors) - 289 have been completed for December (49 % of target completed)** **High Volumes throughout December significantly impacted on the ability to undertake audits**
Floor Walker Audits	59	52	88%	Themes include Wrong Service recommended , Incorrect assessment advice and insufficient probing of the situation .
Health Advisor /clinical Support Targeted audits complaints/ Incidents	55	25	45%	This group has a higher than average failure rate – as these are targeted cases following reported Incidents and Complaints and include ::- Incorrect referral, Demographics, Incorrect pathway , Unsafe Disposition, no assessment undertaken and confidentiality issue Each case audited and any retraining rescheduled Delay to care from incorrect referrals, attitude and incorrect information given to patient about arrival times at OOH
CDSS Clinical Advisor	66	62	94%	**Of the 166 audits scheduled for clinicians, 66 completed of 166 cases (40% of target completed)**
Clinical Navigator	38	34	89%	38 calls audited 34 passed, 2 were partials, 2 were fails• Themes of Fails :Recognising call is complex and should be early exit and passed to clinician and Health Advisors should not be advised to change answer stem to gain a contact disposition
GP	92	79	86%	**Of the 140 audits scheduled for GPs, 92 have been completed (66% of target completed**) Themes of fails - Lacking detail , more probing required, incorrect referral
ACP	68	66	97%	**Of the 148 audits scheduled for ACP, 68 have been completed (68% of target completed)** 2 Fails : Limited History taking and poor documentation

Quality Audit Data December



SEL did not complete the required number of audits for clinical advisors in December due to service pressure

Of the audits completed, quality standards improved to 95.60% compliance, against a target of 86%.



Quality Audit Data December

GP Audit Data	Sept 2019	Oct 2019	Nov 2019
No. of GPs	48	50	56
No. of Total GP Audits	144	150	168
No. achieving compliance	134	137	148
No. non-compliant	9	13	20
No. of GPs with non-compliant audits	8	8	12
Average No. of Audits per GP	3.0	3.0	3.0
Average Audit Score	**87.6% (range 55-100)**	**86.8% (range 55-100)**	**85.1% (range 59-100%)**
% Audit Compliance (target > 80%)	**93.1%**	**91.3%**	**88.1%**

Audit compliance for GPs dropped in November but remain above the 80% requirement

ACP Audit Data	Sept 2019	Oct 2019	Nov 2019
No. of ACPs	22	22	22
No. of Total ACP Audits	66	66	66
No. achieving compliance	58	56	63
No. non-compliant	8	10	3
No. of ACPs with non-compliant audits	6	8	3
Average No. of audits per ACP	3.0	3.0	3.0
Average Audit Score	**84.9% (range 55-100%)**	**85.1% (range 55-100%)**	**92.0% (range 69-100%)**
% Audit Compliance (target > 80%)	**87.8%**	**84.8%**	**95.4%**

Audit compliance for ACPs significantly increased in November

NB reported one month behind

Quality Audit Data December

Pharmacists Audit Data	Sept 2019	Oct 2019	Nov 2019
No. of Pharmacists	4	4	5
No. of Total Pharmacists Audits	12	12	15
No. achieving compliance	12	12	15
No. non-compliant	0	0	0
No. of Pharmacists with non-compliant audits	0	0	0
Average No. of audits per Pharmacist	3.0	3.0	3.0
Average Audit Score	**92.4%**	**91.8%**	**94.0%**
% Audit Compliance (target > 80%)	**100%**	**100%**	**100%**

Pharmacists continue to achieve 100% compliance across all audits

NB reported one month behind

Below are our Audit themes, action being taken to address them and how we share the learning from these across the Trust.

Audit Themes

Role	Theme
Health Advisor	Worsening advice not given Choosing an inappropriate pathway, Missing out pathways questions during assessment.
Floor Walker	Wrong Service recommended Incorrect assessment advice Insufficient probing of the situation .
CDSS Clinical Advisor	No data provided
Clinical Navigator	Recognising call is complex and the need to transfer to clinician
GP	Thorough probing of detail and patient assessment need Incorrect/inappropriate referral
ACP	Limited History taking Poor documentation

Action Plan to address Themes

Probing workshops underway for Health Advisors

Recruitment and training/induction package for Clinical Navigators

Amendment to the Clinical Assessment Template to prompt clinicians to consider elements leading to referral decisions (e.g. Care Plan, CMC, ceiling of treatment)

Alteration to the Clinical Audit tool for Advanced Clinicians to ensure the mandatory use of the Clinical Assessment Template is captured as part of audit.

Action Plan to improve Audit Compliance

Audit responsibilities are going to move away from individual services and be combined across IUC.

This will enable increased oversight of all clinicians, reduce variability and duplication and enable trends to be monitored.

The sessions available for audit will be increased and monitored within month to ensure trajectories are met.

Protected time for auditors will be agreed within CAS escalation policy

3. Caring

We must ensure that the service involves and treats people with compassion, kindness, dignity and respect. Our overall performance in this area over the past month is summarised by our Trust-wide Scorecard.

For further assurance we then provide additional data and analysis on:

- Mental Health
- Maternity
- End of Life
- People and Public Engagement

Outstanding Characteristic: *People are truly respected and valued as individuals and are empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service.*

Trust-Wide Scorecard

Exec Lead: Trisha Bain

Measures	Target / Range	RAG	YTD 19/20	Oct-19	Nov-19	Dec-19	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Data Quality
Mental Health related calls as percentage of all calls			8%	8.3%	7.8%	7.2%	↓				
Mental Health related MPS calls as percentage of all calls			2%	2.3%	2.2%	2.0%	↓				
Mental Health related Incidents as percentage of all calls			5%	5.2%	4.61%	3.79%	↓				
Mental Health related HCP Incidents as percentage of all calls			0%	0.3%	0.25%	0.18%	↓				
Mental Health Related Incidents			77079	8774	8134	7221	↓				
Mental Health Calls closed w ith Hear and Treat			3186	359	384	476	↑				
Mental Health incidents closed w ith See and Treat			38515	5040	4751	4862	↑				
Total MH incidents conveyed as a %			60%	58.7%	60.2%	55.0%	↓				
Mental Health Patients conevyed to an ED			87%	88.5%	87.4%	88.4%	↑				
Mental Health Patients conveyed to an ACP (including other)			13%	11.5%	12.6%	11.6%	↓				
Birth Imminent Incidents			1525	185	170	154	↓				
Conveyance rate of birth imminent			91%	88.0%	90.0%	91.0%	↑				
Head out/head visible Incidents			190	19	26	27	↑				
Haemorrhage after 24 w eeks Incidents			1910	218	219	228	↑				

Mental Health

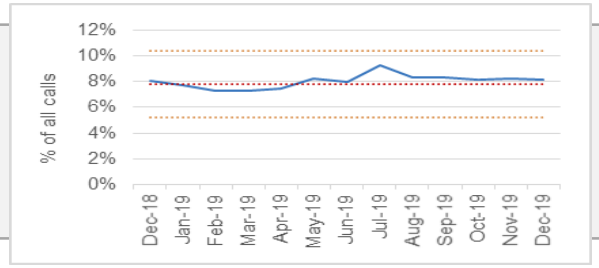
Owner: Carly Lynch | Exec Lead: Dr Trisha Bain

Calls and incidents related to mental health issues often require us to respond differently to other types of patient – ensuring we are able to respond both effectively and with respect is vital for these patients and this is something we are developing through our Pioneering Services Programme (see section 6 of this report)

Trend Analysis

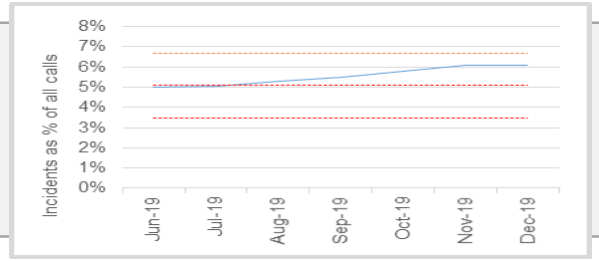
MH as % of all calls

Latest Month: **8.0%**



MH related incidents

Latest Month: **5.3%**



MH Incident Response

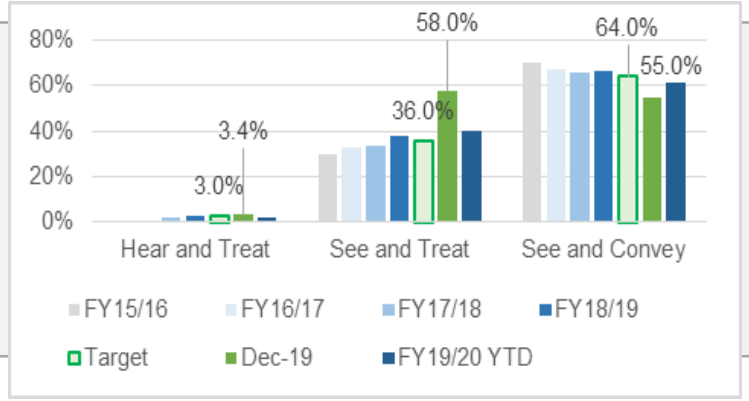


CHART KEY
- Monthly value
- Mean (Baseline FY17/18)
- Upper and Lower Limit (Baseline FY17/18)

Data Source:

- **Highlights**
- Celebrated the 1st birthday of N358 (MH car) at Waterloo Station.
- Team have been focusing on the rapid expansion of the MHJRC over the Winter Resilience Period. Five additional MH cars will be launched in Wimbledon, Greenwich, Chase Farm, Ilford and Wembley.
- We have successfully recruited paramedics for all cars and are interviewing nurses from Mental Health Trusts.
- We will be commencing a training week on 6th January with a go live date for Greenwich and Wimbledon of 13th January.
- We will be commencing a training week on 27th January with a go live date for Chase Farm, Wembley with a go live date of 3rd February. Interviews will be held for the Mental Health Nurses in the coming weeks.

Lowlights

- Some staffing issues to ensure we provide cover for CHUB, MHJRC and support the expansion.

Plans for January :

- Focus on MHJRC expansion

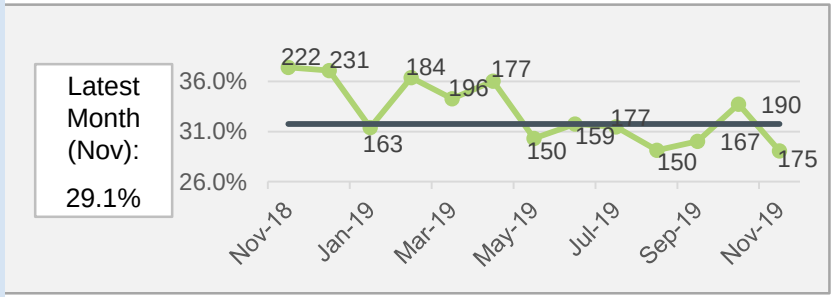
End of Life Care

Owner: Di Laverty | Exec Lead: Dr Trisha Bain

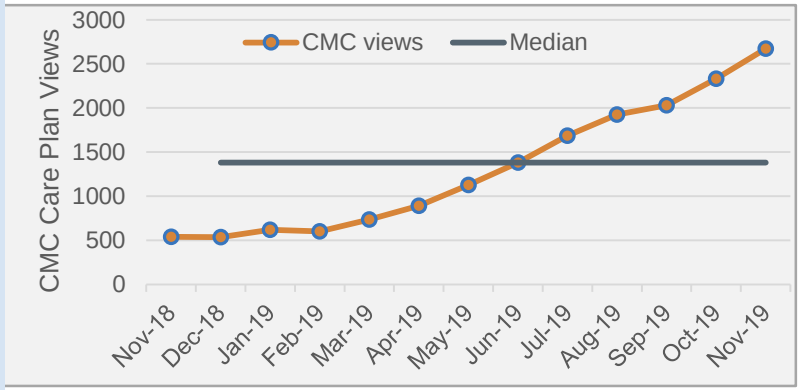
The number of palliative and end of life care patients the service attends is currently underrepresented in the data. The pioneer service aims to improve staff confidence in their skills & knowledge in palliative and EoLC, improve viewing of CMC care plans with a view to decreasing unnecessary ED conveyance and increase ACP utilisation, improve staff wellbeing and involve patients and carers in the programme to guide quality improvement.

Trend Analysis

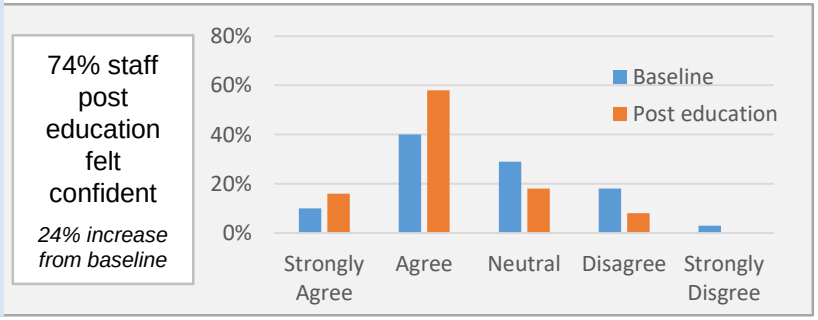
ED Conveyance



CMC Views



Staff Confidence



Highlights

- Annual review presentation to London wide Macmillan team
- Medications and recognition of dying guidance produced and in final stages of approval along with advance care planning guidance updates
- Collaboration with UCL partners for end of life care education materials development
- Exploration of bereavement policy
- Educational podcast recording

Lowlights

CMC viewing figures remain below expected. Chief clinical information officer working with data analyst at CMC to create robust data measures.

Plans for January:

- Patient and carer focus groups commenced
- Exploration of care home data
- Emergency department conveyance- review of cases
- Completion of EOC CMC Coordinator proposal
- Exploration of paediatric guidance and education development
- Hatzola education

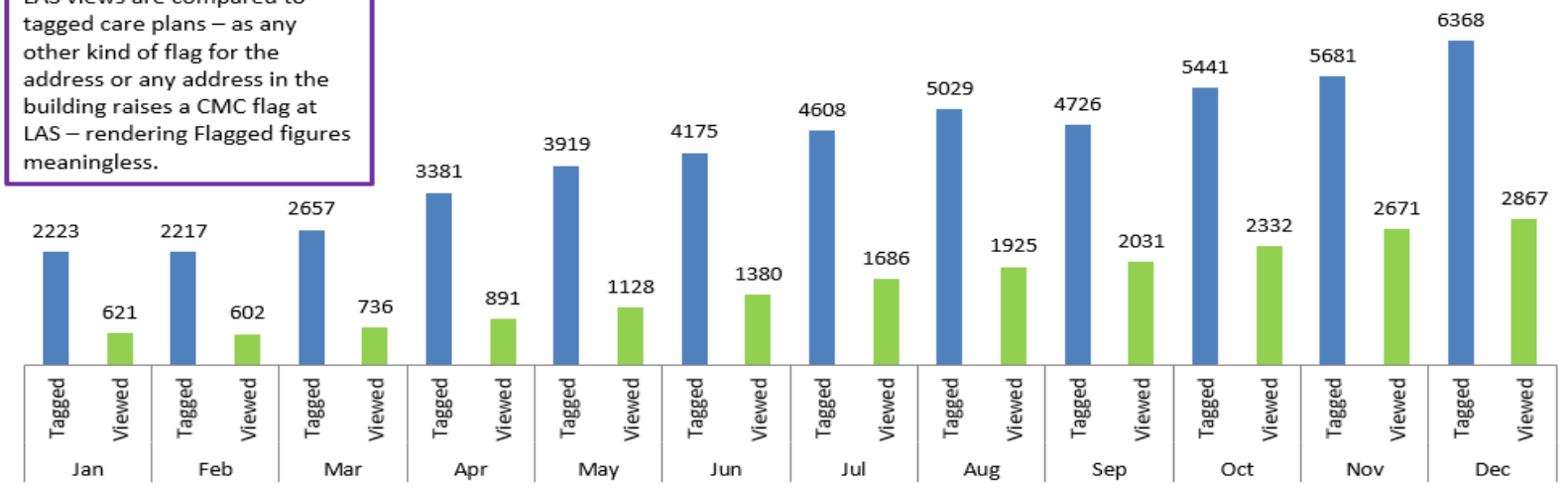
End of Life Care

Owner: Di Laverty | Exec Lead: Dr Trisha Bain

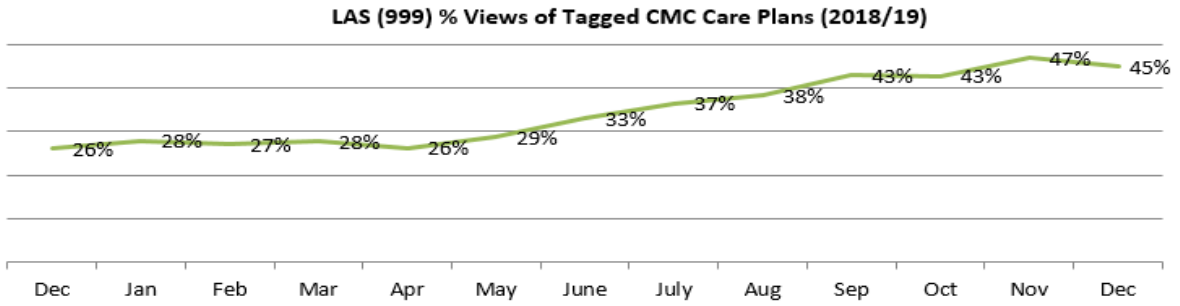
The number of palliative and end of life care patients the service attends is currently underrepresented in the data. The pioneer service aims to improve staff confidence in their skills & knowledge in palliative and EoLC, improve viewing of CMC care plans with a view to decreasing unnecessary ED conveyance and increase ACP utilisation, improve staff wellbeing and involve patients and carers in the programme to guide quality improvement.

CMC Care Plans Tagged by LAS staff as relevant to the 999 call vs Viewed by LAS CMC user (last 12 Months)

LAS views are compared to tagged care plans – as any other kind of flag for the address or any address in the building raises a CMC flag at LAS – rendering Flagged figures meaningless.



Note: *Due to name & address issues at time of call and scope for inaccuracies, the tagging is likely to be on the conservative side. Therefore the LAS views may be a few % points higher than shown.*



LAS (999) *viewed 2867 CMC care plans in December, of which 973 were via iPads (on scene). 36% of care plans were viewed on IPads in November, compared to 34% views via IPads in December.*

4. Responsive

As an organisation we must ensure we are responsive and that services meet people's needs. Our overall performance in this area over the past month is summarised by our Trust-wide Scorecard.

For further assurance we then provide additional data and analysis on:

- Frequent Callers
- Complaints

Outstanding Characteristic: *Services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care.*

4. Responsive

Trust-Wide Scorecard

Exec Lead: Trisha Bain

Measures	Target / Range	RAG	YTD 19/20	Oct-19	Nov-19	Dec-19	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Data Quality
Rate of Frequent Callers per 1,000 Calls			3.54	4.10	4.20	4.10	↓				
Number of Frequent Caller calls			67692	7128	7393	7784	↑				
Total Frequent Callers			5451	690	701	736	↑				
Number of LAS accesses to CMC care plans			2019	891	1128	1925	↑				
Percentage of view ed CMC care plans			29%	26%	29%	33%	↑				
Rate of Complaints per 1,000 incidents			0.94	1.0	0.9	0.9	↓				
Complaints Response (35 Working Day Breach) YTD			174	13	18	13	↓				
Complaints Acknow ledged w ithin 3 w orking days			100%	100%	100%	100%	↔				

Owner: John O'Keefe/ Juliette Smyth | Exec Lead: Trisha Bain

Highlights

- Meeting with Legal services to explore possibility of a Trust policy on private proceedings for frequent callers where police are not involved.
- Attended LGM team meeting to highlight closer joint working and importance of accessing CMC plans for frequent callers.
- Further meeting held with Medical Directorate, CHUB and Mental Health to assess feasibility of Restricted Send call management plans for complex, prolific callers, similar to that used successfully by East of England Ambulance Service. Monthly meetings to continue. The intended outcome is to reduce dispatches, save resources, improve road staff morale and patient outcomes through a more consistent, boundaried approach with positive risk-taking call management plans.

Lowlights

- Ongoing challenges in seeking dedicated BI input for database development work and frequent caller dashboard. This would demonstrate the organisational impact of interventions to both the service and the patient, specifically in reducing despatches and conveyances.
- Ongoing challenges with supporting crews in managing chaotic, drug seeking patients using aliases, who call from multiple locations, where an IDP flag cannot be reliably linked to the patient. An internal alert system for crews with patient descriptions is needed - IG & Legal guidance required to clarify options.

Plans for January

- Meeting with Comms to arrange a Facebook live Q&A to raise awareness and support staff with frequent callers.
- Attending Ambulance Frequent Caller National Network quarterly meeting, hosted by North West Ambulance Service.
- Paper regarding Restricted Sends is being presented to EXCO in January. This process

Owner: John O'Keefe/ Juliette Smyth | Exec Lead: Trisha Bain

National definition of a **frequent caller** is anyone aged 18+ years who:

- Calls 5+ times in one month from a private dwelling; or
- Calls 12+ times over a three month period from a private dwelling

New & existing callers	736
NHS numbers matched	100%
Stakeholder meetings attended	49

Cluster	CCG	Patients	Dec-19	Calls last quarter	Calls last 12 months	12 month cost
NC	ENFIELD CCG	34	716	1533	3920	£445,147
SW	WANDSWORTH CCG	23	467	1116	2342	£233,939
SE	LAMBETH CCG	35	427	1340	4158	£512,805
NE	TOWER HAMLETS CCG	24	379	849	2122	£318,366
NE	CITY AND HACKNEY CCG	40	326	1000	3091	£425,597
NW	EALING CCG	29	319	966	2594	£290,004
NW	HAMMERSMITH AND FULHAM CCG	20	286	680	1978	£257,625
SW	CROYDON CCG	33	284	738	2392	£359,273
NC	BARNET CCG	43	280	1041	2620	£360,246
NW	HILLINGDON CCG	23	280	674	2021	£278,915
SE	SOUTHWARK CCG	27	276	808	2193	£316,028
NE	NEWHAM CCG	25	256	712	1738	£270,756
SE	GREENWICH CCG	23	252	744	2079	£287,015
NE	BARKING AND DAGENHAM CCG	25	245	617	1751	£247,135
NC	HARINGEY CCG	28	241	648	2192	£246,142
SE	LEWISHAM CCG	32	237	837	2234	£330,128
NE	REDBRIDGE CCG	19	225	526	1538	£200,786
NC	ISLINGTON CCG	24	224	645	1578	£245,771
SW	MERTON CCG	18	220	580	1956	£294,719
NW	HOUNSLOW CCG	21	202	632	2882	£216,135
NW	CENTRAL LONDON (WESTMINSTER) CCG	19	200	729	2922	£295,966
NC	CAMDEN CCG	18	194	555	1660	£169,513
NW	HARROW CCG	17	179	657	1655	£179,034
NW	WEST LONDON CCG	24	168	607	1671	£212,397
NE	WALTHAM FOREST CCG	17	166	654	2094	£195,699
SW	RICHMOND CCG	15	163	435	1461	£176,059
NE	HAVERING CCG	11	161	459	1226	£160,277
SE	BROMLEY CCG	19	116	411	975	£151,130
SW	SUTTON CCG	15	92	302	1028	£167,017
NW	BRENT CCG	17	90	382	1034	£148,608
SE	BEXLEY CCG	12	78	253	1369	£119,360
SW	KINGSTON CCG	6	35	131	292	£42,889

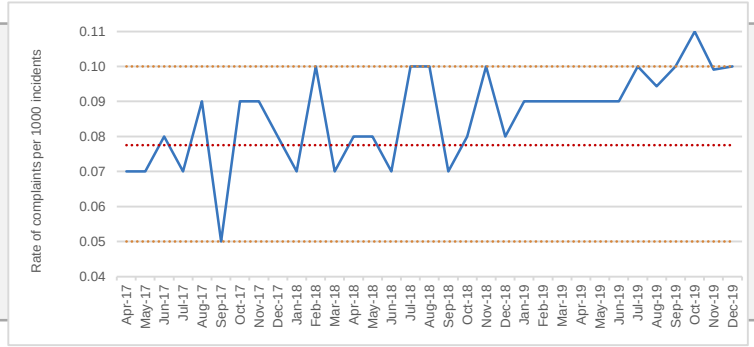
Complaints

Owner: Gary Bassett | Exec Lead: Dr Trisha Bain

Complaints are an integral way of enabling the Trust to receive patient and public feedback about their experience of our service

Rate of Complaints

Latest Month: **0.10**

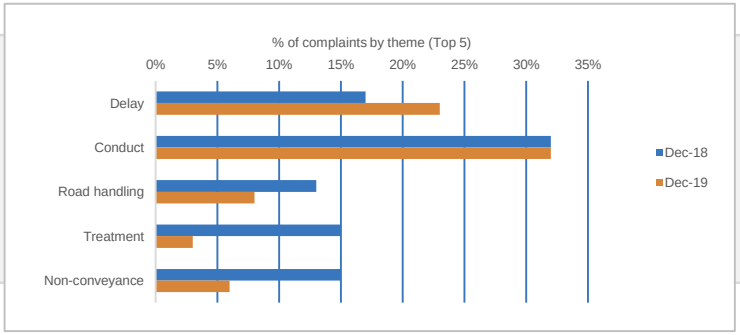


In November and December we received a total of 199 complaints which was higher than anticipated but slightly lower than previous months. The current trajectory of complaints for 2019/20 remains at 1030

We managed 635 PALS enquiries during this period – similar to previous months. We record SAR's as PALS and a number of these have become more complex

We managed 61 Health Partner (Quality Alerts) in this period.

Categorisation

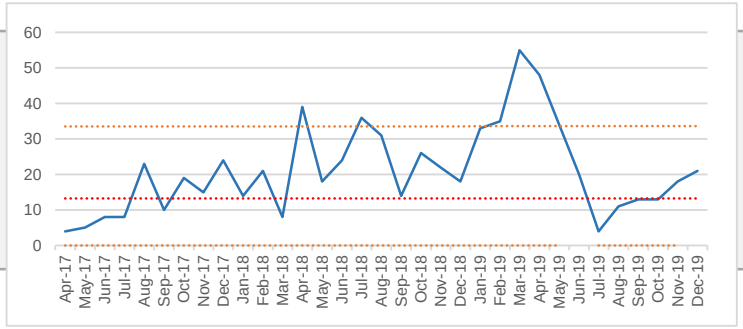


Conduct and behaviour complaints currently account for 31% of total complaints received in 2019/20. Where the key head of complaint is delayed response, the percentage is 15%

There were 17 complaints attributed to NHS111 in November and December, 7 related to NELIUC and 10 from SELIUC. A number of these were reported directly to the Patient Experiences Department by the complainant.

Responding to complaints

Latest Month 13



There were 18 complaints that breached the 35 day response target in November and 21 in December. The annual average for 2019/20 is that 77% of complaints were responded to within 35 working days. (611/793 due in the period November to December 2019)

This represents a slight dip over previous months. We are continuing to work alongside our stakeholders to make further improvements to throughput.

Owner: Gary Bassett | Exec Lead: Dr Trisha Bain

Case examples

Case Example

We received a complaint from the patient's father who is concerned at the delay in attending his baby son and that the call handler did not obtain full details of his son's injury

The Quality Assurance evaluation concluded that the initial 999 call was poorly managed. Although it was recorded that the child had a leg injury, the call handler made several technical errors when applying the assessment questioning which resulted in their omitting to explore whether the patient had any obvious deformity to the injured leg, which - if so - would have prompted an ambulance being arranged from the outset, most likely at a Category 3 priority.

The call handler also omitted to record that the patient was situated in a public place; although this would not have had any bearing on the call priority, it should have been highlighted.

As remedial action and in keeping with our learning practice, extensive feedback will be given to the call handler concerned.

Actions and Learning

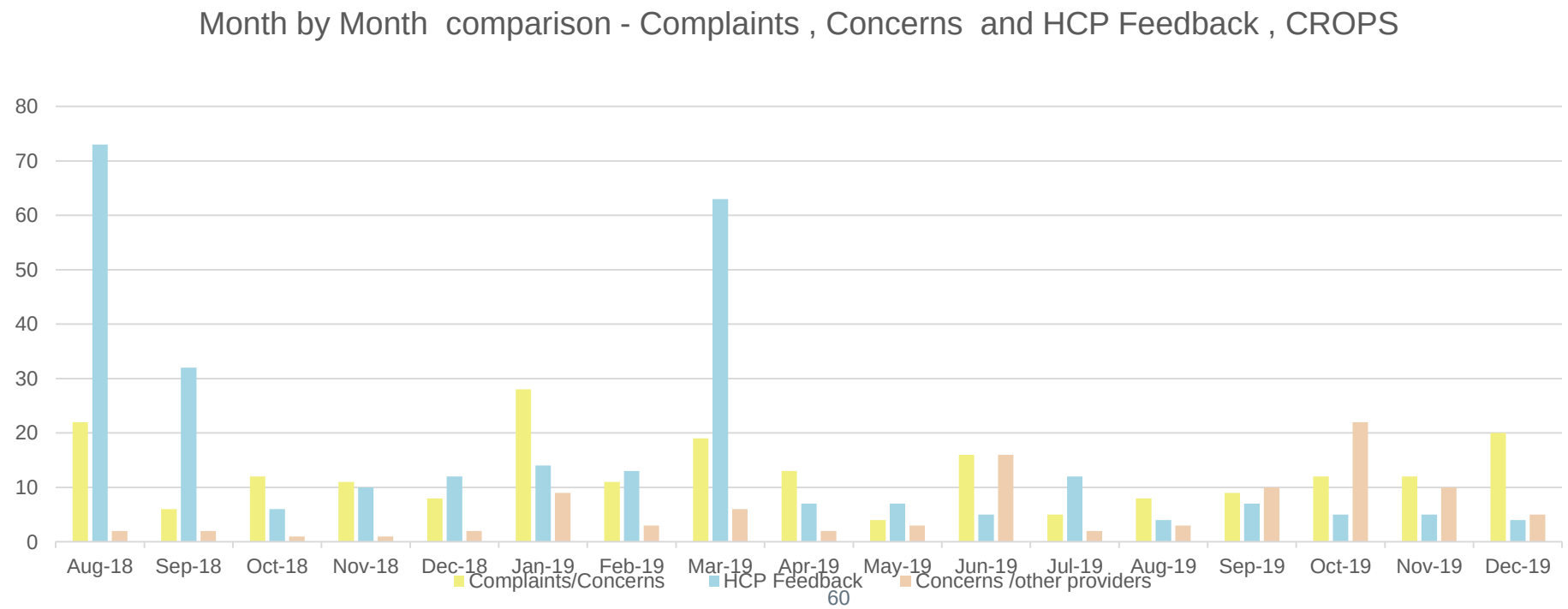
Department issues

- November and December have continued to be busier than 2018 with an overall 5% increase in complaints for 2019/20 over 2018/19
- Pressures on our internal stakeholders have impacted on recent throughput. This is particularly relevant with Quality Assurance reports and Clinical Hub reviews
- The Directorate Heads of Department will be meeting to discuss the way forward with QA's to improve turnaround and PED will request access to Adastra
- We have recently recruited 2 Patient Experiences Manager posts and will shortly hold a workshop with the team to look at phase one of the new way of working and how we need to improve the process with the implementation of phase 2
- It is anticipated that going forward and in conjunction with our stakeholders we will draft the revised process and put into place some interim measures

- We have deferred the implementation of the duty team as the team are undergoing a number of staff changes
- One of our officers has been successful in a secondment to East of England Ambulance Service and we are seeking a replacement
- The staff changes have impacted on the skill mix of the team
- Currently 7 cases are being considered by the PHSO
- There are 11 complaints/Quality Alerts that are the subject of a Serious Incident Investigation
- We plan to liaise with internal operational managers and QGAM's to improve the way in which we identify learning from complaints and how we disseminate that in the future

HCP Feedback and Complaints

Type AP	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov 19	Dec 19
Complaints /Concerns	22	6	12	11	8	28	11	19	13	4	16	5	8	9	12	12	20
HCP Feedback	73	32	6	10	12	14	13	63	7	7	5	12	4	7	5	5	4
Concerns /other providers	2	2	1	1	2	9	3	6	2	3	16	2	3	10	22	10	5
Total	87	40	19	22	22	51	27	88	22	14	37	19	15	26	39	27	29



HCP Feedback and Complaints

Oct	Complaints/Concerns	HCP Feedback	Concerns-re other providers	Total
Open	10	1	0	11
Closed	10	3	5	18
Totals for Month	20	4	5	29

Key
Green : Closed
White : Under Review
Blue : Totals

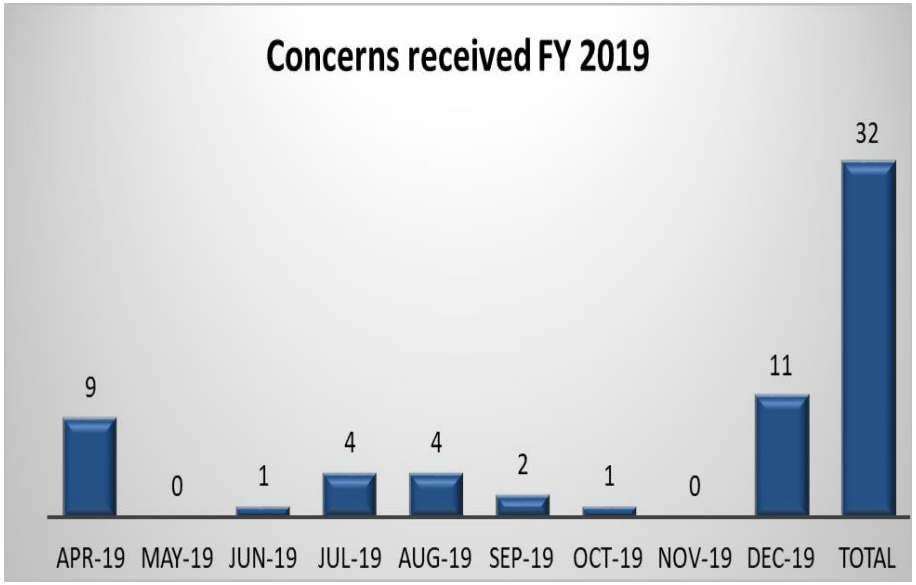
Summary outstanding by Month	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Totals
Complaint	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
HCP Feedback	0	0	0	0	0	1	0	0	0	0	0	0	0	0	4	1	**6**
Concern	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	10	**13**
Concern Other Providers(crops)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	**1**
Total	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**8**	**11**	**20**

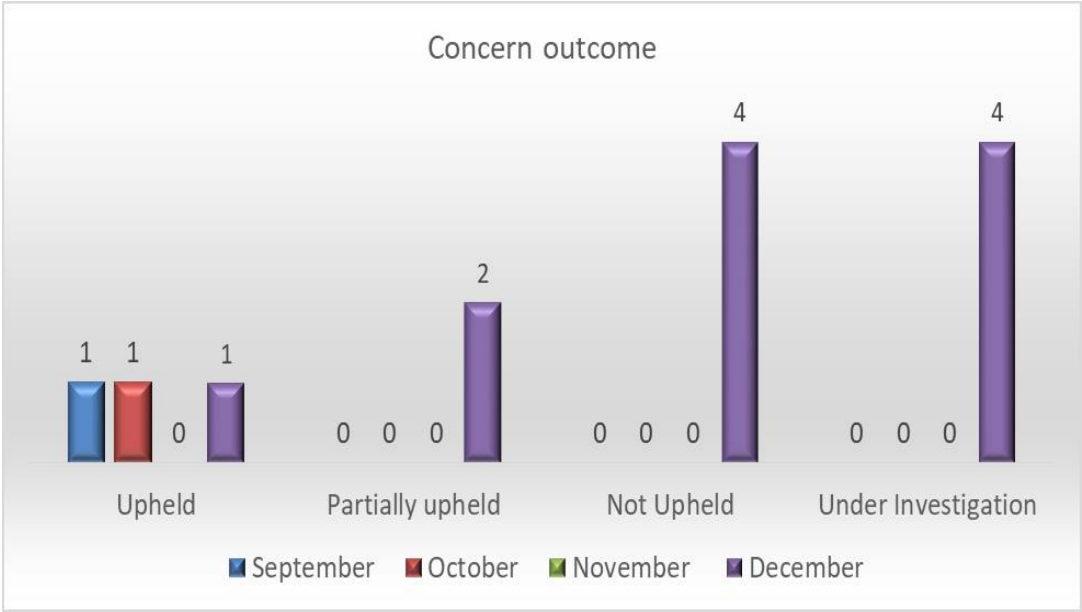
Outstanding cases by Month and by Category.

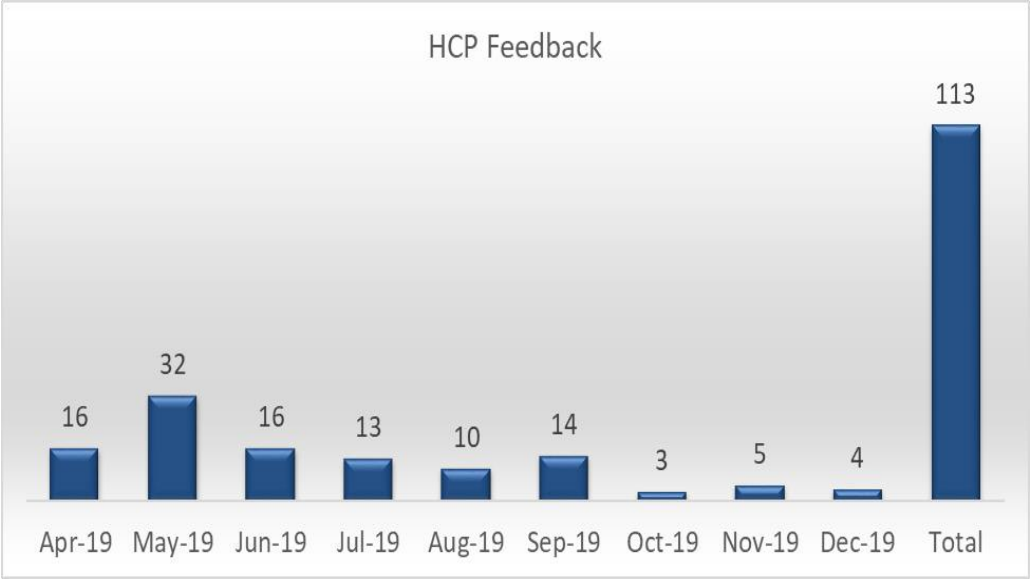
Outstanding items – all have been investigated and are under audit review or feedback.

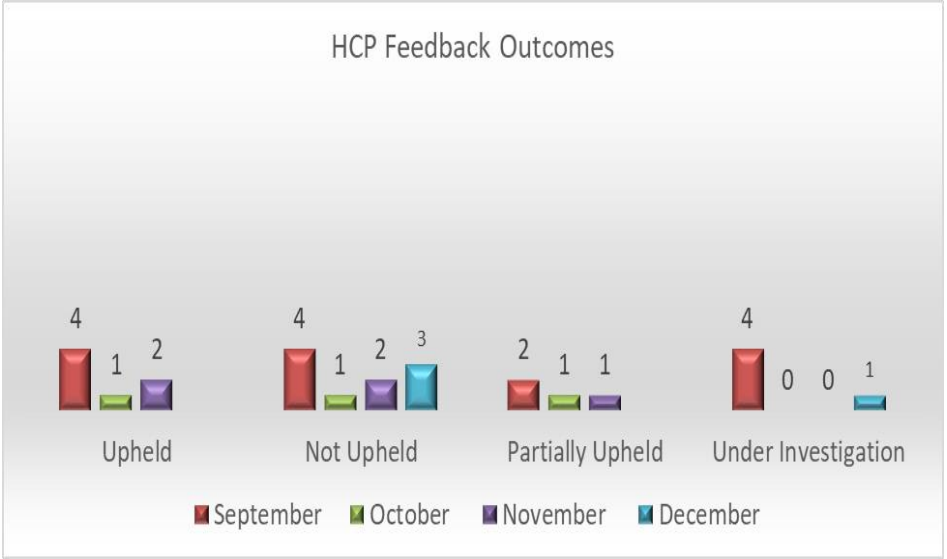
Feb HCP Feedback outstanding is currently with Legal for response- holding response has been sent to the originator currently with QGAM

All Outstanding HCP Feedbacks have been reviewed and are with Clinical Lead for review and response.


Concerns received FY 2019
9
0
1
4
4
2
1
0
11
32
APR-19
MAY-19
JUN-19
JUL-19
AUG-19
SEP-19
OCT-19
NOV-19
DEC-19
TOTAL


Concern outcome
1
1
0
1
0
0
0
2
0
0
0
4
0
0
0
4
Upheld
Partially upheld
Not Upheld
Under Investigation
September
October
November
December


HCP Feedback
16
32
16
13
10
14
3
5
4
113
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Total


HCP Feedback Outcomes
4
1
2
4
1
2
3
2
1
1
4
0
0
1
Upheld
Not Upheld
Partially Upheld
Under Investigation
September
October
November
December

Below are our HealthCare Professional feedback and Complaints themes, action being taken to address them and how we share the learning from these across the Trust.

Outcomes and Themes

	Theme
HCP Feedback	8 submitted across both IUC sites 2 Partially Upheld, 1 rejected (sent to NE Sector) and 4 Not upheld. 1 under investigation Both the Upheld feedbacks related to patients who has been told they had appointment times booked at Urgent Treatment Centres, when the advice should be given to the patient that it is an arrival time and as UTC also has walk in patients a priority triage system is in place.
Complaints	31 complaints(formal) and concerns (informal) received across both sites. 14 still under investigation, 17 closed. Of the 17 closed, 65% (n=11) were upheld Themes were: - Appointment time was given instead of Arrival time (n=2) - Location of booked appointment given incorrectly (n=2) - Delay in re contacting patient due to CAS queues (n=4) - Attitude (n=1)

Action Plan to address Themes

'Take 5 to say Arrive' comms campaign to be launched to address regular arrival time complaints

DoS team requested to change location details of a site currently undergoing building works – DoS instructions contributing to patients being sent to wrong location

Clinical Navigator recruitment and rota review in progress to ensure at peak times call demand can be managed to minimise delay in call backs

Individual performance and attitude concerns receive feedback from team managers

Sharing Learning from Feedback and Complaints

Joint Governance Meeting between NEL and SEL enables themes and actions to be shared.

Actions from complaints resulting in concise or comprehensive Root Cause Analysis are shared cross site and with EOC as appropriate.

Learning from Experience infographics released to staff

61 responses were received from patient surveys conducted by telephone and letter.

Highlights

- 93% (n=57) followed advice given, demonstrating confidence in our service
- 67% (n=41) did not contact another healthcare provider in the five days after their call, suggesting they were managed effectively
- 62% (n=38) of patients would have contacted 999 or gone to ED if 111 was not available. This would significantly increase demand on other areas of LAS and London.
- Only 7% (n=4) of patients would not recommend 111 to family and friends

Lowlights

- The demographic of survey respondents does not wholly represent the demographic of the STPs in which we provide services

Next Steps

- Patient groups are being set up to enable broader representation of communities within the STPs

Learning From Deaths, Inquests and Claims

Owner: Sue Watkins| Exec Lead: Philippa Harding

Inquests

Latest Month: **1.1**

	Oct-18	Nov-18	Dec-18		Oct-19	Nov-19	Dec-19
Total Prevent Future Deaths in Month	0	0	0		0	1	0
Total Inquests where LAS asked to give evidence - In month	7	6	1		2	9	4
Total Inquests where LAS asked to give evidence - Year to date	39	58	59		48	57	61

- 1 Regulation 28 PFD report was received in November 2019.

- Legal Services received one Regulation 28 PFD report in November 2019. This was relating to the London Bridge Terrorist attack 2017. The Trust responded ahead of the deadline of 10th Jan 2020.

- The LAS has received 1 PFD for noting following an inquest in October 2019 (letter received December 2019). The Coroner was informing of a PFD issued against an Acute Trust where medication doses differed from LAS clinician in that they worked in Mgs and not Mls. This deputy medical director is reviewing JRCALC and other relevant guidance to ensure this is resolved.

Data Source: Datix

Owner: Sue Watkins| Exec Lead: Philippa Harding

Claims

NHS Resolution data - Claims received Oct-Dec 2019

	Oct	Nov	Dec
CNST	1 Fail/Delay Admitting To Hosp.	2 Delay ambulance service to attend a patient suffering an asthma attack. In labour, gave birth in ambulance baby fell on to the rubber floor of the ambulance	Awaiting Data
LTPS	3 Slip or Trip Assault Prov & Use of Personal Prot Equip Regs	4 Manual handling injury caused by lifting equipment bags to patient. Went to sit on seat in back of ambulance when seat collapsed and claimant fell through and struck metal frame. Slipped on oil. Faulty garage door closed on claimant unexpectedly	Awaiting Data

Claims Closed with damages Oct-Dec 2019

	Oct	Nov	Dec
CNST	0	0	Awaiting Data
LTPS	0	1	Awaiting Data

Claims Closed without damages Oct-Dec 2019

	Oct	Nov	Dec
CNST	0	3	Awaiting Data
LTPS	4	3	Awaiting Data

Data Source: Datix

Learning From Deaths, Inquests and Claims

Owner: Sue Watkins| Exec Lead: Philippa Harding

Claims

NHS Resolution Data – OPEN Claims to date

Section	Clinical Non Clinical	Scheme	Schedule Name	Speciality1L1	No of Claims	Damages Paid	Defence Costs Paid	Claimant Costs Paid	Total Paid
Open	Clinical	CNST		Ambulance	41	14,277,270	987,342	3,117,500	18,382,112
				Cardiology	1	10,000	4,288	0	14,288
				Emergency Medicine	1	0	7,225	0	7,225
				Gastroenterology	1	0	11,064	0	11,064
				Neurology	2	1,529,637	104,670	370,000	2,004,307
				Orthopaedic Surgery	1	17,000	2,274	0	19,274
				Plastic Surgery	1	0	1,964	0	1,964
				Psychiatry/ Mental Health	1	5,000	9,748	5,000	19,748
				Respiratory Medicine/ Thoracic Medic	1	0	15,323	0	15,323
			Total		**50**	**15,838,907**	**1,143,898**	**3,492,500**	**20,475,304**
		Total			**50**	**15,838,907**	**1,143,898**	**3,492,500**	**20,475,304**
	Non Clinical	LTPS	EL Portal		2	100,477	21,304	27,000	148,781
			Empl Liab		47	74,693	44,324	4,647	123,663
				Unknown	2	325,627	42,088	60,205	427,920
			PL Portal		1	0	0	0	0
			Public Liab (PL)		9	10,000	4,119	15,108	29,227
				Unknown	1	0	0	0	0
			Total		**62**	**510,797**	**111,834**	**106,960**	**729,590**
		Total			**62**	**510,797**	**111,834**	**106,960**	**729,590**
	Total				**112**	**16,349,703**	**1,255,732**	**3,599,460**	**21,204,895**

Data Source: Datix

5. Well Led

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.

In this section we examine whether the actions we are taking to support the Quality of the organisation are having the necessary impact.

Outstanding Characteristic: *The leadership, governance and culture are used to drive and improve the delivery of high-quality person-centred care.*

5. Well Led 2019/20 Quality Priorities

Priority area on or ahead of target | Domain area on track
Priority area off target but no escalation | Domain area off target but no escalation
Priority area off target escalation required | Domain area escalation required

London Ambulance Service NHS Trust

Quality Domain	Quality Priorities from Quality Account	Status	Q3 Update
Safe	*Over 90% implementation of all actions in the Gosport Enquiry Action Plan by April 2020*	Amber	The group are on track to achieve the majority of actions from the plan, however not 90%. Prescribing guidance has been produced for End of Life Care. The group are working closely with Independent Ambulance Authority. IUC work is on-going, quarterly report produced and submitted to NEL Commissioners.
	>90% completion of actions on the trust-wide security implementation plan	Green	100% risk mitigating actions completed. 92% completed overall.
	Increased scores in relation to learning from and reporting incident in the annual staff survey compared to April 2019 baseline	Green	My organisation encourages us to report errors, near misses or incidents - 2017 (84%) and 2018 (88%) When incidents are reported, my organisation takes action to ensure that they do not happen again - 2017 (52%) and 2018 (59%) We are given feedback about changes made in response to reported incidents - 2017 (45%) and 2018 (54%) 2019 Staff survey was sent to staff in September and closes on 29th November. Results will be available during Q4.
	Reduction in both incident of and sickness rates for MSK injuries from April 2019 baseline	Green	Although the figures fluctuate month on month, in Q3 the average rate was 0.46 reported MSK incidents per 1000 A&E (face to face) incidents. YTD the average rate of 0.44 reported MSK incidents per 1000 A&E incidents. The analysis indicates the overall MH sickness (working days) rate trend is down-word. Sickness has fluctuated as well, however the average number of working days lost due to MSK injuries is 1.84 per 1000 A&E (face to face incidents), YTD the average is 3.11.
Effective	*Reduce the average handover to green response time in all sectors from 17 minutes to 15 minutes by April 2020*	Amber	Trust-wide, year to date handover to green response time is 16.4. Q3 average per sector: NC – 15.8; NE – 16.5; NW – 16.03; SE – 16.2; SW – 16.02
	Meet service wide NHS 111 and IUC quality targets evidenced via agreed indicators by April 2020. Increased consultant complete episodes from April 2019 baseline	Amber	In Q3 consult and complete figures remained consistently at around 26% in NEL and 21% in SEL, against the target of 33%. The 95% target for call backs within their priority timeframe was not met, showing a downward trend and increased call back times across Q3 in both NEL and SEL IUC. Commissioners across both STPs are engaged with the Trust in a comprehensive recovery and improvement plan to address challenges meeting KPIs.
	A reduction in nature of call incidents from January 2019 baseline	Green	There have been zero incidents to date. This is following the implementation of many actions discussed in the SI reports declared last year and improvements in technology and QA tools changes.
Caring	*Mental Health response car service to be rolled out across a minimum of the South East sector during 2019-20*	Green	We have recently celebrated the 1st birthday of the Mental Health response car at Waterloo Station. The team have been focusing on the rapid expansion of the service to provide more winter resilience. Five additional MH cars will be launched in Wimbledon, Greenwich, Chase Farm, Ilford and Wembley and have successfully recruited paramedics and nurses from Mental Health Trusts for the cars.
	Evidence of increase in skills and knowledge for staff groups in supporting patients who are at the end of their lives	Green	Participants rating as confident post bespoke Education/ End of Life Care coordinators CPD event= 70%. An increase in 20% from the baseline. Staff confidence is reflected in the reduction in Emergency Department conveyance by an average of 10% this financial year, meaning more patients are supported at home towards the end of their lives. The team are currently exploring and reviewing the internal care after death process.
	Ensure that over 90% of NHSI patient involvement KPIs are met during 2019-20 from January 2019 baseline	Green	79% completed, on track to achieve target. A new patient engagement strategy has been written and there have been 261 events to date. We increased the number of staff that are trained to deliver presentations in a volunteer capacity, this allows our public education officers to focus on new projects. We have begun to participate in the 'Safety First' project alongside the other Blue Light services and received external funding to recruit two new Public Education Officers.
Responsive	*To be in the top 3 ambulance trusts demonstrated by our score on the aggregate AQIs, consistently throughout 2019-20*	Amber	Based on the aggregated AQI's, the Trust has been ranked (YTD): • Top performing Trust for Category 1 response times • 4th top performing Trust for Category 2 response times • 3rd top performing Trust for Category 3 response times Due to changes in the way that Ambulance data and acute services map patient data There may be some delays reporting on some indicators.
	To respond to over 75% of patients complaints within the 35 day target from the 68% April 2019 baseline	Green	The annual average for 2019/20 is that 77% of complaints were responded to within 35 working days. (174 complaints breached YTD) Q3 – 44 complaints breached the 35 working day target.
Well led	*Gain a rating of 'good' for the Use of resources domain in the 2019-20 CQC inspection*	Green	The organisation has been informed that the CQC will not be inspecting the Use of Resources domain during their 2019-20 inspection. CQC inspection took place in September 2019 and the report was published on 3rd January 2020. The Trust received a "Good" rating overall.
	Quality Improvement teams in each sector and sector quality improvement programmes developed and delivered by April 2020	Green	An extension of the Quality Intelligence and Risk team has been proposed, with a new role for QI Hub Facilitators, 1 post funded with a view to invite secondments to the team for up to 5 further QI Hub Facilitators. This post will support the introduction Quality Improvement Hubs (model and proposal under development) within each sector. Job description for QI facilitator has been drafted and recruitment should commence in Q4.

The CQC rated LAS as Good for being effective, caring, responsive and well-led. It was rated Requires Improvement for being safe, following the inspection in September 2019.

Overall there were enough front-line ambulance staff to care for patients and keep them safe. Staff had training in the key skills needed for their role. The inspectors found LAS staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions.

The service ran well using reliable information systems and supported staff to develop their skills. Most staff understood the service's vision and values, and how to apply them in their work. Staff also felt respected, supported and valued.

Inspectors found evidence of some outstanding practice including playing a leading role in the creation of the London Digital Board and other stakeholders to shape a clearly aligned strategy for integrated working.

However, there were some areas where the Trust must improve including:

Actions:

Identified relevant actions will be monitored 2 monthly via the Chief Operating Officer's SMT with updates being included in future quality reports. All actions will also be implemented into relevant action/improvement plans with updates regularly submitted to QOG and QAC and the Board.

Learning from our actions

Exec Lead: Dr. Trisha Bain & Dr. Fenella Wrigley

ER Excellence Reporting
Excellence is everywhere

103 Excellence Reports were submitted in November including the follow:

"(A multi-casualty RTC). On my arrival they were providing excellent patient care and scene management, with limited resources as there were multiple patients. The crews were working well together and effectively utilising the LFB and police on scene. The scene was well managed and very safe.

These are difficult calls, however, the crews all worked diligently and professionally, and supported myself and the HEMS team to provide the highest standard of care."

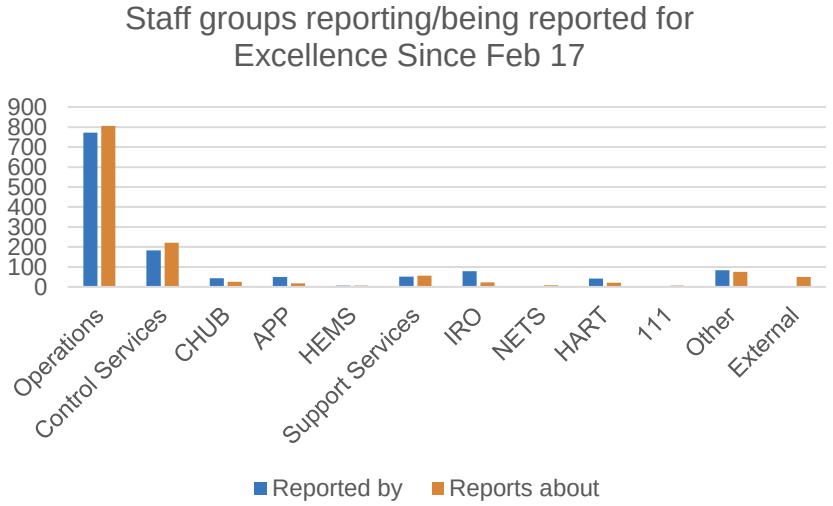
"EOLC patient, covered all aspects of care and further management with professionalism, respect and kindness. Ensuring the patients last hours of life were comfortable and his wishes observed."

"This member of staff has been a real team player over this weekend. We have been very short of staff in the control room with specifically trained staff.

We asked if he would step up and cover the call taking supervisor position, without training and using his previous knowledge in call taking. He has a "can do" ethos, happy to help and quietly confident. He has sat and worked in this potion on his own for several long periods in challenging times without a moan an always cheerful."

"Crew noticed and followed up on case of potential neglect of an elderly person. Completed safeguarding referral and also consulted with line manager to ensure their concerns were appropriately acted upon in a professional manner."

"Arrived at a Cardiac arrest in a public place to find a calm, well executed resus taking place. All staff working as a team, communication was excellent, and each with their own role firmly in hand. The scene was very public, in a shop foyer and all LAS staff were professional, compassionate, thoughtful and helpful which made the call run really smoothly."



Learning from our actions

Exec Lead: Dr. Trisha Bain & Dr. Fenella Wrigley

Find the story of the 100th excellence report on the Pulse:

Celebrating our 1000th excellence report

Monday 9 December

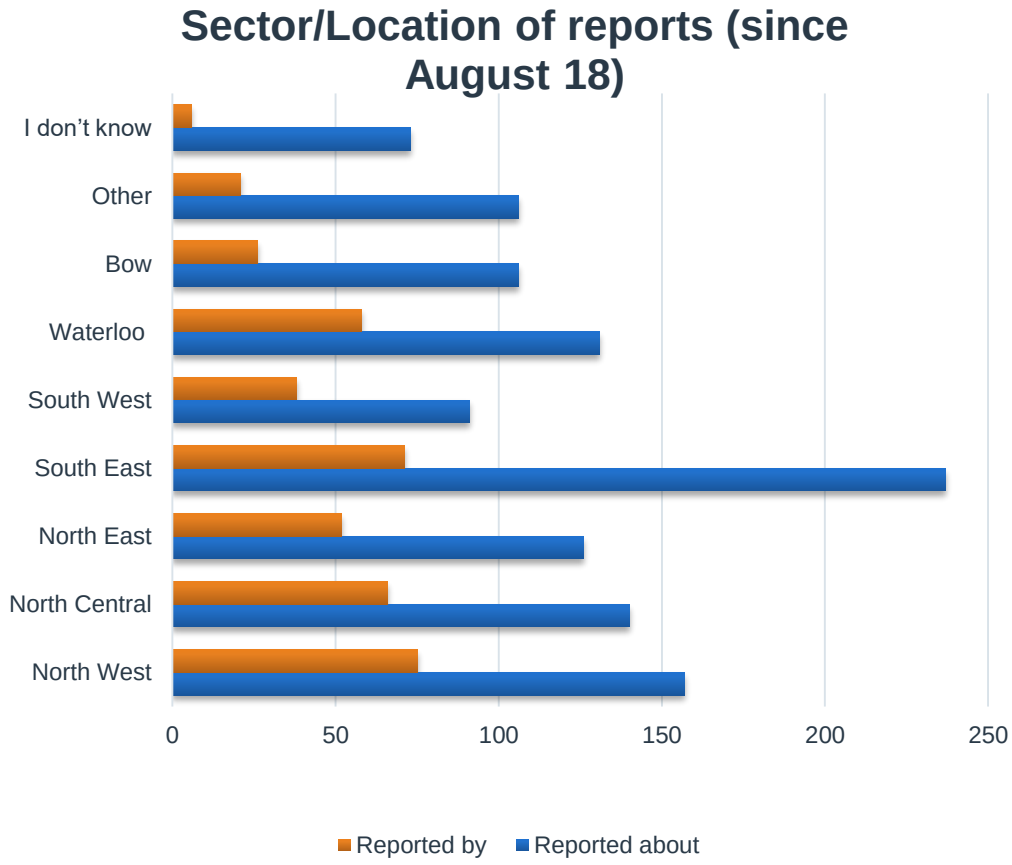
Excellence is everywhere around the Service and since the excellence reporting tool was put in place, we are now delighted to announce that we have reached our 1000th report of excellence - and what an excellent one it is.

Will Ashby, Trainee Emergency Ambulance Crew (TEAC), based in Westminster, witnessed a cardiac arrest on his way home from training school. Thanks to his quick actions, the patient - a 40 year old mother of four - survived the incident and has been discharged from hospital.

Charlotte Coutts, Incident Response Officer, was so impressed by Will's actions on that day, that she completed an excellence report, so that Will could be acknowledged for his hard work.

Charlotte wrote: "I would like to make you aware of an exceptional member of staff. Could you please pass on my appreciation for the hardwork and professionalism displayed by Will Ashby. I attended an incident for a female who was witnessed to collapse and found in VF arrest. Will was walking past on his way home from training and rendered aid. Will arrived prior to the Service and started CPR and assisted our crews on their arrival. This lady later had ROSC and was transported to hospital. We now know this lady - a mother of four - survived and was discharged from hospital.

Will informed me that he had never witnessed a cardiac



IUC Programmes of Work to Improve Quality

IUC Improvement Plan

The IUC Improvement Plan continues.

In December, 2 actions closed; Recruitment of NEL GP Clinical Lead confirmed (started 07/01/2020) and CAS/CHUB C5 collaboration (commencing 10/01/2020)

- **63 actions in total**
- **28 actions remain**
- **28 actions closed**
- **7 held by other workstreams but progress and oversight is monitored through action plan**

CQC Inspection

CQC inspection from September 2019 rated IUC 'Good' overall. 'Good' rating received in all domains with exception of effective

CQC action setting meeting planned for January 28th to launch CQC towards outstanding refreshed plan, incorporating the 'must do's' and 'should do's' as featured in the report.

Regulatory report received for following improvements;

Monitor the quality of GP decision making in relation to the prescribing of medication.

Review the process in place for monitoring the call quality of operational staff.

Review the process in place for disseminating information to staff

Staff Engagement

IUC staff invited to undertake 999 Observer days arranged to improve working with colleagues in the 999's

Caring for Women Experiencing Pregnancy Loss: A New E-learning Resource shared with all Clinical Staff

"It's OK not to be OK!" – Staff Mental Health Welfare awareness scheme promoted for this time of the year

Joint NEL & SEL IUC Clinical Educational Event took place, well received with good feedback

FLU FIGHTERS campaign continues with c 40% of all staff having received vaccination so far

6. Clinical and Quality Risks

To run an efficient organisation we need to manage the important and unique risks we face as an ambulance service.

This section summarises the **most significant clinical and quality risks** that we are actively managing as part of the Quality Directorate risk register.

Clinical and Quality Risks Summary

Exec Lead: Dr. Trisha Bain & Dr. Fenella Wrigley

There are currently 36 risks recorded on the Clinical and Quality Directorate Risk Registers. These risks sit across other sectors/areas of the Trust as well as within the Clinical and Quality Directorate.

There were 3 amber risks added regarding Safeguarding training and referrals being misidentified as welfare (due to recent changes in process) and incorrect information being given at EoLC CPD events. Work is underway to mitigate these risks.

Three risks were closed as they had been resolved, these were unauthorised access to patient information in CARU, delays in CARU reporting and addresses of patients on CMC not being flagged in a timely manner.

There two red new red risks this month are the same discussed in the last quality report. These are being addressed accordingly in order to reduce the risk down over the coming months.

Clinical and Quality Risks Overview

	Negligible	Minor	Moderate	Major	Catastrophic	Total
Almost certain	0	0	2	0	0	2
Likely	0	0	5	0	0	5
Possible	0	2	13	6	0	21
Unlikely	0	1	4	3	1	9
Rare	0	0	0	0	0	0
Total	0	3	24	9	1	37

The two red risks on the clinical and quality risk registers:

ID 945: *There is a risk to the integrity of the data being produced by Kitprep due to the system not working as expected which leads to inaccuracy in the Perfect Ward audit tool of expiry dates of drug packs and discrepancies when reconciling the number of drug packs with the system.*

Update: IM&T actions have been taken including UAT testing. Following review and go live in the next few weeks this risk is likely to be closed.

ID 928: *There is a risk to research and planning caused by the introduction of the national data opt-out service which allows patients to opt out of their confidential patient information being used for research and planning. Patients can view or change their national data opt-out choice at any time by using the online service. Therefore every new data extract would be required.*

Update: CARU are continuing to explore with NHS Digital. National opt out project has been completed and LAS are current exempt from the opt out but will change soon as move collecting NHS number.

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	28 January 2020			
Report title:	Integrated Quality and Performance Report			
Agenda item:	Additional report, circulated for information only			
Report Author(s):	Key Leads from Quality, Finance, Workforce, Operations and Governance			
Presented by:	Key Leads from Quality, Finance, Workforce, Operations and Governance			
History:	N/A			
Status:	☒	**Assurance**	☒	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

This high level Integrated Quality and Performance Report serves to provide an Executive Summary for the Board and give organisational oversight of all key areas across London Ambulance Service NHS Trust (LAS).

This report brings together the areas of Quality, Operations, Workforce and Finance.

It enables effective monitoring and highlighting of potential issues to inform the business decisions of the Trust.

Key messages from all areas are escalated on the front summary pages in the report.

It is designed to highlight key risks and support benchmarking of Trust-wide performance against Key National, Local and Contractual Indicators.

Recommendation(s):

The Board is asked to note the Integrated Performance Report and receive it for information, assurance and discussion.

*Please note that the data is correct as at 8 January 2020 for the Patients section / Public Value is showing November 2019 due to unavailability of December 2019 data. Data is subject to change.

Links to Board Assurance Framework (BAF) and key risks:

This report contains an overview of Trust Risks directly linked to the BAF but does not itself raise any risks.

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☐
Performance	☐
Financial	☐
Workforce	☐
Governance and Well-led	☐
Reputation	☐
Other	☐

This paper supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

NHS
London Ambulance Service
NHS Trust

London Ambulance Service – Integrated Performance Report

Report for discussion with Trust Board members

Analysis based on Year to December 2019 data, unless otherwise stated

Our Patients – Data is at 8th January 2020 and is subject to change | Public Value – Data presented is for November 2019

Contents Page

Overview

We have structured our management of performance and business plan around our organisational goals: **our patients, our people, our partners and public value**:

	Update on performance:	**Achievements since the last Board** (incl. reference to Business Plan deliverable):
Provide outstanding care for **our patients**	999 Performance in all national measures have broadly remained stable over time, however October – December were a challenging period with a larger than expected number of calls and incidents. December 2019 saw the busiest month on record for high acuity and all demand. 999 call taking performance was also challenged due to a high level of incoming calls, especially in the 2 weeks leading up to Christmas, however work is ongoing to improve on call answering 90th centile. 111 Performance remains challenging, although has stabilized. Calls answered within 60 seconds SLA was stable over October – December, however remained below target. Work continues to develop the Clinical Assessment Service with Commissioners especially with regards to the flow of cases through the service; enabling the Trust to enhance KPI compliance within the 7 Priorities.	• *When benchmarked across 13 key metrics included in the National Ambulance Services Balanced Scorecard, the Trust fluctuated in performance in October - December. However, we were frequently best in class for the Category 1 Mean and 90th Centile measures.* • *NEL/SEL call answering performance continues to improve with some measures now above the national target*
Be a first class employer, valuing and developing the skills, diversity and quality of life of **our people**	Our overall vacancy rate is below our 5% target at 2.7%. Over 400 Paramedics have started/expected to join the Trust between April 2019 and March 2020. We are forecasting an overall end of year 'in-ops' gap of 114fte frontline posts. Our turnover continues to improve at 10.4%. Trust compliance in Statutory and Mandatory training has improved to 84% against our 85% target and over 4,000 E-Learning Courses were completed in December.	• *Staff Survey Response rate of 71.5% achieved.* • *Staff Turnover rates improved to 10.4%.* • *Stat and mandatory training improved to 84%* • *The 'in-ops' vacancy rate for our frontline registered and non-registered staff is 3.4% (114fte vacancies)*
Provide the best possible value for the tax paying **public**, who pay for what we do	The Trust year to date position at the end of November (month 8) was a £3.3m deficit, which was £1.3m worse than plan year to date but represented an improvement in month and on the previous trend. The Trust identified a number of significant risks to delivery of its control total earlier in the year and has mitigated a number of these through discussions with commissioners. A number of risks remain and the Trust continues to focus on reducing cost through its financial recovery plan and is still projecting to deliver its agreed control total. The Trust has a use of resources score of 3 at the end of November, which is in line with plan. The Trust is planning a year end score of 1	• *The Trust has agreed a contract settlement with commissioners for 19/20, a cap and collar arrangement with a maximum payment of £373m. Commissioners have also agreed to fund £2.5m towards the total cost of the in-year pressure TEAC cost pressure. This payment is made on a non-recurrent basis and future management of this cost pressure will need to be addressed as part of the 2020-21 contracting round.* • *The Trust Cash position has improved significantly in year and is £2.3m above plan at 30th November, however this is mostly driven by slippage in the capital investment plan which is expected to catch up over the year*
Partner with the wider NHS and public sector to optimise healthcare and emergency services provision across London	There has been a significant increase in hospital delays in December with over 3,600 hours lost to over 30 min handovers as we see ED's across the country seeing high demand and long wait times. Handover to Green exceeded the trust target in December due to concentrated effort to improve on this metric. ED conveyance during December was comfortably with target. On going dialogue continues to happen between the LAS and our commissioners to finalise the baseline figures for 2019/20 ED Conveyance and H&T activity. Our national position saw us achieve 5th best for H&T, leaving us at 7th position for ED conveyance. The impact of the NEL Perfect Day, which took place for 16 hours during November 2019 demonstrated the benefits of enabling the LAS 999 clinical HUB to focus on different categories of patients and the power of connecting the LAS 999 clinical HUB with downstream services (including Primary care, community services, mental health, pharmacy and dental. Plans are on going to prepare for the Perfect Quarter.	• *We are contributing to the Collaborative Contact & Response (CCR) programme. This programme has now been established with baseline assessments and scoping completed (BP19).* • *We have a achieved the ED conveyance target in December (BP19).* • *H&T performance is steadily improving in 2019/20 and was above target in December*

Trust-Wide Scorecard - 999

Patients Scorecard

December 2019

Indicator (KPI Name)	Basis	Data From Month	Target Status	Current Perfomance: Target & Type (Internal / Contractual / National / All)		Current Perfomance: Latest Month	Current Perfomance: Year To Date (From April)	Current Perfomance: Rolling 12 Months	Benchmarking (Month): National Data	Benchmarking (Month): Best In Class	Benchmarking (Month): Ranking (out of 11)
Category 1 response – Mean	mm:ss	Dec-19		07:00	A	00:07:01	00:06:34	00:06:32	07:35	07:02	1
Category 1 response - 90th centile	mm:ss	Dec-19		15:00	A	00:11:45	00:11:00	00:10:54	13:18	11:45	1
Category 1T response – 90th centile	mm:ss	Dec-19		30:00	N	00:20:25	00:19:22	00:19:29			
Category 2 response – Mean	mm:ss	Dec-19		18:00	A	00:26:42	00:20:22	00:20:27	0:28:08	0:14:56	4
Category 2 response - 90th centile	mm:ss	Dec-19		40:00	A	00:57:41	00:42:11	00:42:28	0:58:57	0:28:09	4
Category 3 response – Mean	h:mm:ss	Dec-19		1:00:00	A	01:30:42	01:02:33	01:02:11	1:31:16	1:01:08	5
Category 3 response - 90th centile	h:mm:ss	Dec-19		2:00:00	A	03:45:35	02:31:08	02:30:31	3:40:42	2:24:05	5
Category 4 response - 90th centile	h:mm:ss	Dec-19		3:00:00	A	04:11:00	03:27:53	03:22:42	03:47	03:11	7
Call Answering Time - 90th centile	ss	Dec-19		24	I	35	56	48			
ROSC at Hospital	%	Aug-19		33%	N	31.4%	33.9%	34.5%	31.2%	35.9%	3
Severe Sepsis Compliance - (national AQI reported quarterly)	%	Jun-19		N/A		89.9%	89.9%	N/A	77.6%	89.9%	1

*National average YTD

Benchmarking Key

- Top 3
- Ranked 4-7
- Ranked 7+

Please note:

999 performance data is correct as at 08/01/20 and is subject to change due to data validation processes

- G — KPI on or ahead of target
- A — KPI off target but within agreed threshold
- R — KPI off target and outside agreed threshold
- KPI not reported / measurement not started

Variation Indicators

*Note: **ROSC at Hospital and Sepsis** is measured quarterly*

Patients Scorecard (NEL IUC)

December 2019

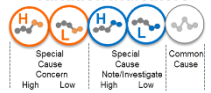
Indicator (KPI Name)	Basis	Data From Month	Target Status	Current Perfomance: Target & Type (Internal / Contractual / National / All)		Current Perfomance: Latest Month	Current Perfomance: Year To Date (From April)	Current Perfomance: Rolling 12 Months	Benchmarking (Month): London Data	Benchmarking (Month): Best In Class	Benchmarking (Month): Ranking (Pan London)
Percentage of answered calls answered in 60 seconds	%	Dec-19	R	95.0%	A	64.9%	78.5%	77.8%	67.4%	76.4%	4
Percentage of calls abandoned after 30 seconds	%	Dec-19	R	5.0%	A	6.0%	3.8%	3.8%	6.1%	3.5%	3
Total calls - Priority 1: dealt within 15 min	%	Dec-19	R	95.0%	C	64.3%	67.5%	62.7%			
Total calls - Priority 2: dealt within 30 min	%	Dec-19	R	95.0%	C	43.9%	57.8%	56.0%			
Total calls - Priority 3: dealt within 60 min	%	Dec-19	R	95.0%	C	31.7%	54.7%	52.1%			
Total calls - Priority 4: dealt within 120 min	%	Dec-19	R	95.0%	C	27.6%	56.4%	55.0%			
Total calls - Priority 5: dealt within 180 min (NEL only)	%	Dec-19	R	95.0%	C	46.5%	65.1%	66.1%			
Total calls - Priority 6: dealt within 240 minutes	%	Dec-19	R	95.0%	C	47.6%	70.0%	71.3%			
% of calls closed with no onward referral (health advisor and clinician)	%	Dec-19	R	33.0%	A	27.7%	27.6%	27.3%			
% of calls transferred to 999	%	Dec-19	G	10.0%	A	8.5%	7.8%	7.7%	9.9%	7.8%	2
% of calls recommended to ED	%	Dec-19	R	5.0%	A	8.5%	9.2%	9.0%	9.3%	9.3%	1

Benchmarking Key

- Top 3
- Ranked 4-7
- Ranked 7+

- G — KPI on or ahead of target
- A — KPI off target but within agreed threshold
- R — KPI off target and outside agreed threshold
- KPI not reported / measurement not started

Variation Indicators



Patients Scorecard (SEL IUC)

December 2019

Indicator (KPI Name)	Basis	Data From Month	Target Status	Current Perfomance: Target & Type (Internal / Contractual / National / All)		Current Perfomance: Latest Month	Current Perfomance: Year To Date (From April)	Current Perfomance: Rolling 12 Months	Benchmarking (Month): London Data	Benchmarking (Month): Best In Class	Benchmarking (Month): Ranking (Pan London)
Percentage of answered calls answered in 60 seconds	%	Dec-19	R	95.0%	A	76.4%	77.6%	77.2%	67.4%	76.4%	1
Percentage of calls abandoned after 30 seconds	%	Dec-19	G	5.0%	A	3.5%	3.6%	3.6%	6.1%	3.5%	1
Total calls - Priority 1: dealt within 15 min	%	Dec-19	R	95.0%	C	54.4%	76.0%	76.3%			
Total calls - Priority 2: dealt within 30 min	%	Dec-19	R	95.0%	C	36.8%	53.6%	54.1%			
Total calls - Priority 3: dealt within 60 min	%	Dec-19	R	95.0%	C	29.1%	60.3%	60.2%			
Total calls - Priority 4: dealt within 120 min	%	Dec-19	R	95.0%	C	38.8%	64.5%	65.0%			
Total calls - Priority 6: dealt within 240 minutes	%	Dec-19	R	95.0%	C	57.5%	75.4%	75.6%			
Total calls - Priority 7: dealt within 360 min (SEL only)	%	Dec-19	R	95.0%	C	69.8%	80.9%	82.0%			
% of calls closed with no onward referral (health advisor and clinician)	%	Dec-19	R	33.0%	A	29.6%	28.0%	26.8%			
% of calls transferred to 999	%	Dec-19	G	10.0%	A	7.8%	8.3%	8.3%	9.9%	7.8%	1
% of calls recommended to ED	%	Dec-19	R	5.0%	A	8.9%	9.1%	9.1%	9.3%	9.3%	2

Benchmarking Key

- Top 3
- Ranked 4-7
- Ranked 7+

- G — KPI on or ahead of target
- A — KPI off target but within agreed threshold
- R — KPI off target and outside agreed threshold
- KPI not reported / measurement not started

Variation Indicators

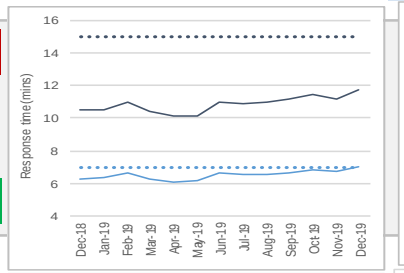
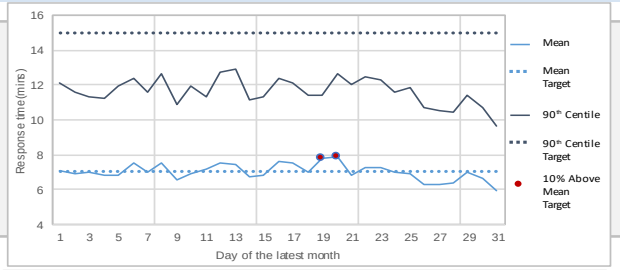
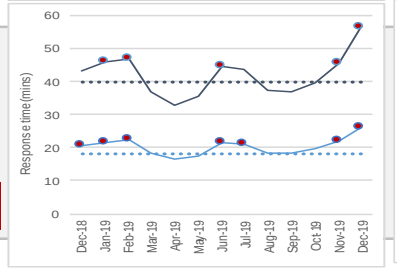
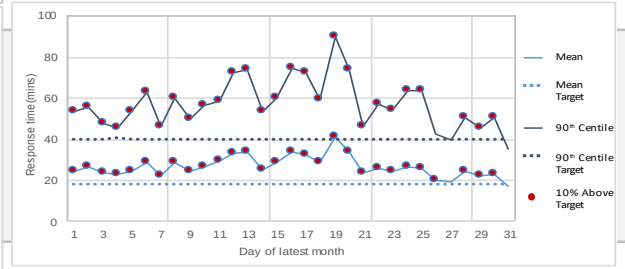
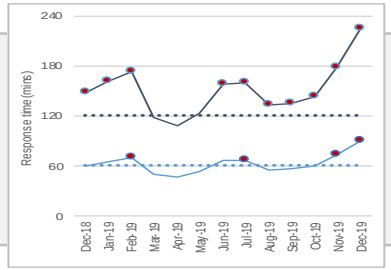
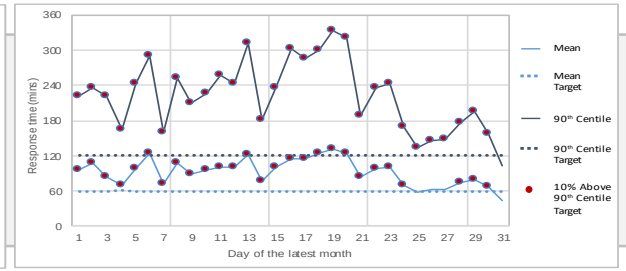
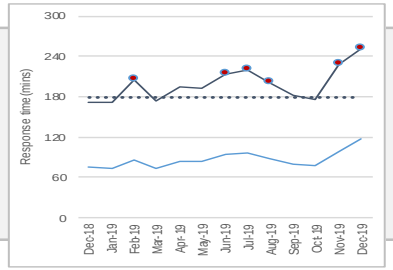
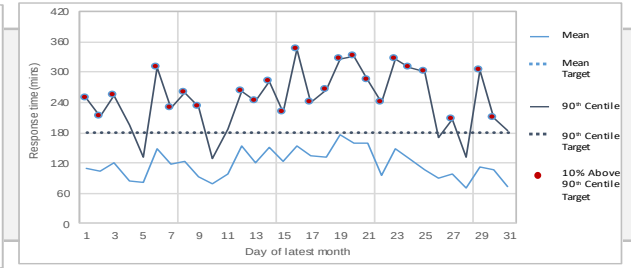
1. Our Patients

999 Response Time Performance

The December Category 1 mean returned 7 minutes 1 seconds while the Category 1 90th centile was 11 minutes 45 seconds. The Category 1 90th centile which had previously remained within the standard since the implementation of the Ambulance Response Programme (ARP) was just over the standard in December due to severe pressures the system was under. December 2019 saw the highest demand ever in LAS impacting on our C2 and C3 performance.

Please note:

999 performance data is correct as at 08/01/20 and is subject to change due to data validation processes

		Monthly Trend	Daily Analysis	
C1	**Mean: 7:01** Target: 7:00 **90th Centile: 11:45**			The C1 mean performance was just outside of the ARP target in December 2019 while the system was under severe pressure. The C1 90th centile shows monthly performance successfully within the national standard of 15 minutes, which is also reflected in the year to date position and indicates a safe level of service is being provided in this category.
C2	**Mean: 26:10** Target: 18:00 **90th Centile: 56:41**			During October – December 2019, our C2 mean and 90th centile both were outside the target. We had a steady increase of the number of incidents of Cat 1 and Cat 2 combined in the run up to winter. Two weeks prior to Christmas, we saw a challenging period between 8th and 20th December in terms of demand for our high acuity demand. Four of these days were the busiest recorded exclusive of New Years Day.
C3	**Mean: 30:17** Target: 2:00:00 **90th Centile: 03:45:14**			Similar to C2, our C3 performance 2 weeks prior to Christmas saw a significant increase in our demand impacting on our ability to deliver on these categories. C3 90th centile has been challenged, remaining above the national standard of 2 hours most months. In December the performance overall was just well outside the target. The Trust are working to reduce longer waits for this category of patients.
C4	**90th Centile: 04:10:31** Target: 3:00:00			C4 90th centile performance was also challenged in October – December. Due to the balance leaning towards the higher categories and high demand overall compared to 2018/19, this continues to be challenged. The Trust are working to reduce longer waits for this category of patients.

1. Our Patients

999 Response Time Performance

Operational Demand

The level of demand each month has a direct relationship on our performance metrics. Ensuring we make the most appropriate response is critical to managing demand effectively and therefore making the most of our resources and capacity to respond to our most critical patients.

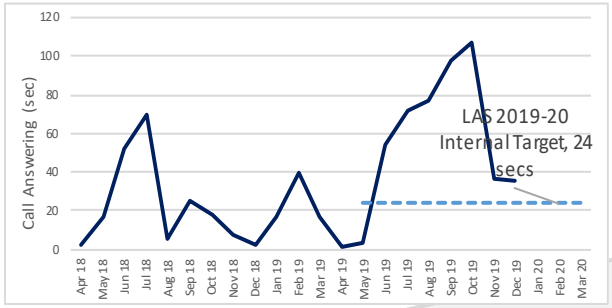
The analysis below describes: **1)** Calls Received, **2)** Incidents and Response Type (incl. Hear & Treat, See & Treat, See & Convey), **3)** Incident Category

Please note:
999 performance data is correct as at 08/01/20 and is subject to change due to data validation processes

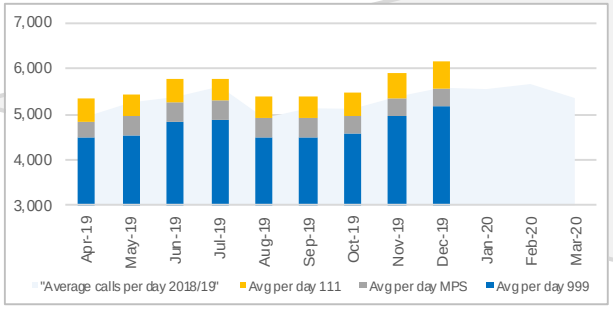
999 Calls Received

October - December 2019 saw a higher number of calls compared to an equivalent period in 2018. Call answering performance is back on track following a difficult first 2 weeks in December after a robust period of operational grip. This continues to happen and work is ongoing to achieve an internal target of answering 90th centile, which is less than 24 seconds.

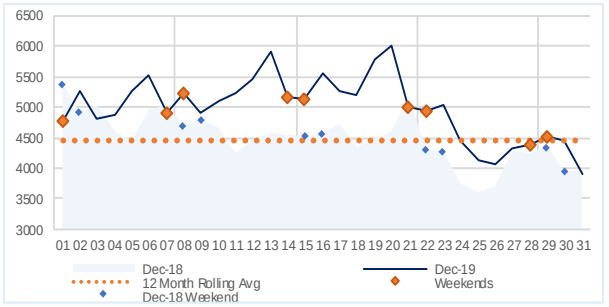
Performance (90th Centile)



Average Calls Per Day



Daily Calls Answered

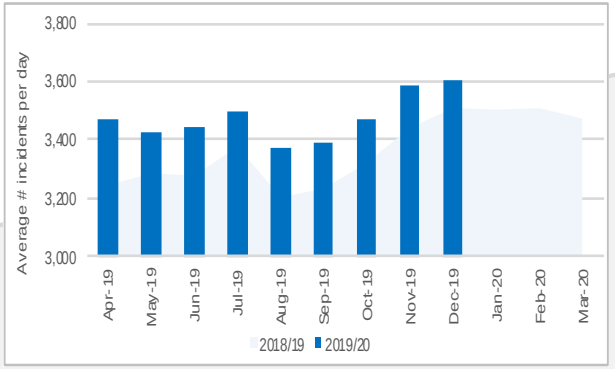


Incidents and Response Type

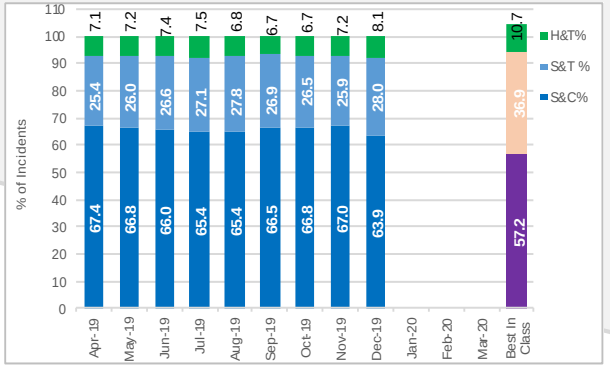
October – December 2019 delivered continued pressure on the Trust, with the average number of incidents per day remaining higher than in 2018. December 2019 saw approximately a 2% increase compared to December 2018 resulting in our busiest month ever in regards to demand for the LAS.

Performance improved for ED conveyance and Hear and Treat compared to 2018/19 due to concentrated effort on improving these measures.

Incidents



Response Type

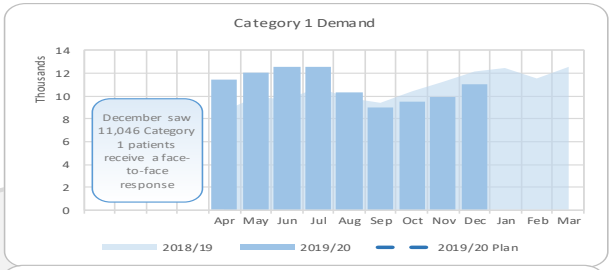


During December 2019, SWAS was best in class achieving 36.9% and 57.2% for their S&T and S&C outcome; leaving the LAS at 26.6% (7th place) and 63.4% (7th place) for these response types.

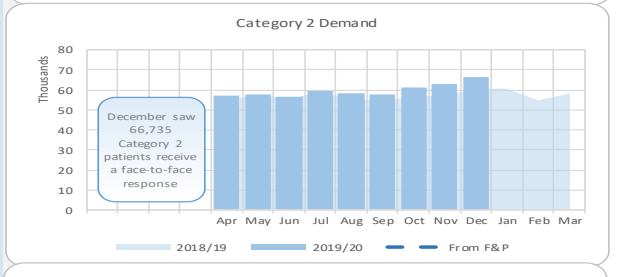
IOW was best in class for achieving H&T at 10.7%, with LAS in 5th place with 8.1%

Incident Category (By Month)

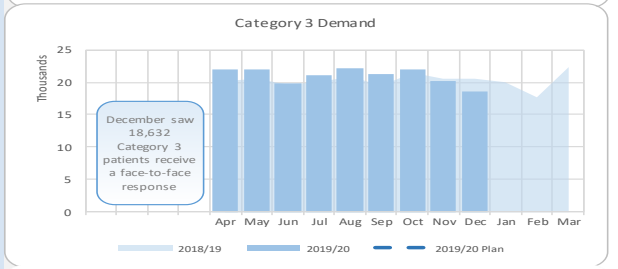
C1



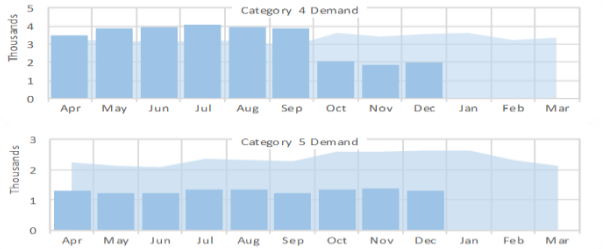
C2



C3



C4/C5

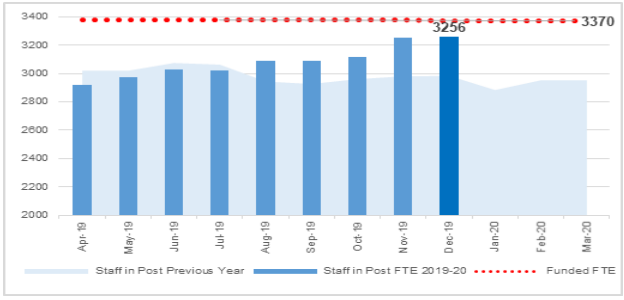


Our ability to meet this demand is dependent on our operational capacity and our ability to minimise the time that this unavailable. We consider two aspects of our capacity: our operational staff and our fleet of response vehicles.

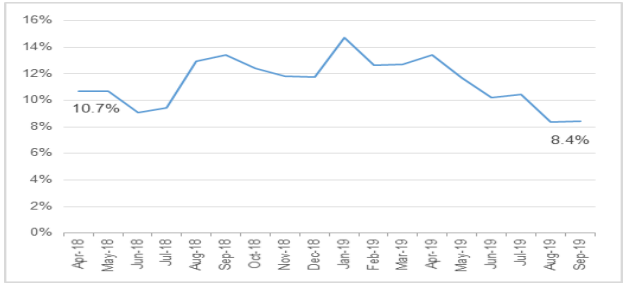
Frontline Operational Staff

The number of filled operational FTE has shown a stable shortfall over 2018/19 and we continue to place considerable effort into our recruitment and retention activity. There has been recruitment improvement in April/May 2019 compared to the same period last year. (See Our People section of this report for further detail across the organisation)

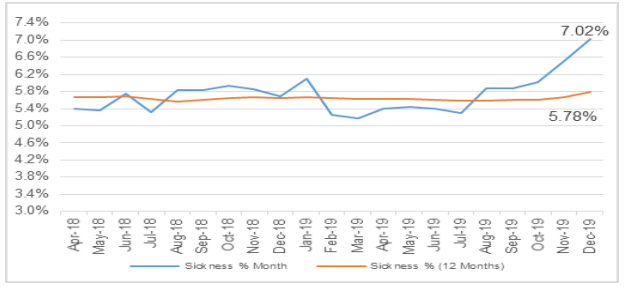
Filled FTE



Vacancy Rate



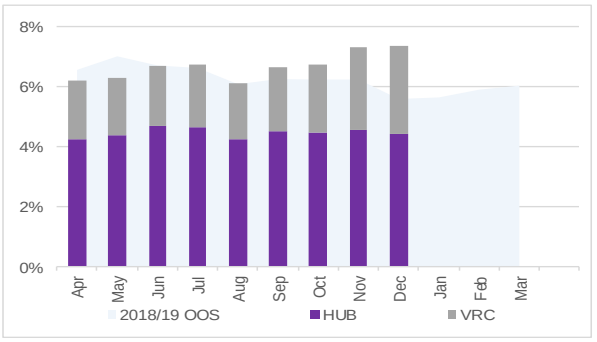
Sickness Rate



Vehicle Availability and Patient Facing Hours

Overall Out Of Service rate has gone up over the recent months. The new DCA Project Team have delivered 21 new DCAs (to date) into the front line, increasing the total DCA fleet to 451 vehicles. The Operational Placement Crews will be decreasing in numbers mid-January 2020. Both these factors will have a positive impact on DCA vehicle availability and assist in ensuring DCA crews have a vehicle at the start of their shift. The recruitment of Fleet Operational Support Managers is now complete and this will provide robust monitoring of the workshop performance and smarter working practises which will also provide an increase in frontline vehicle availability. The Trust has provided an average of 7,786 patient facing vehicle hours per day in December. This is significantly over the number of hours provided in 2019 and corresponds with the increase in demand.

Out Of Service %

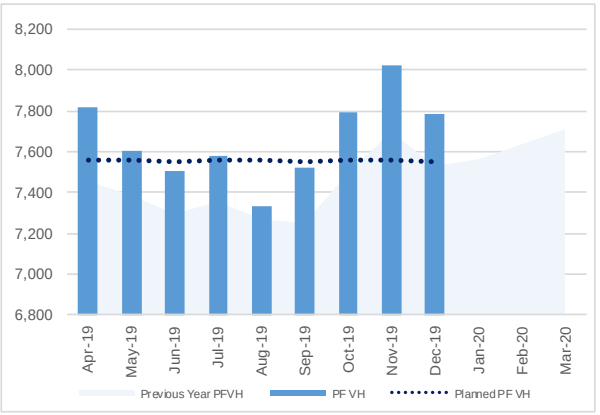


Note:

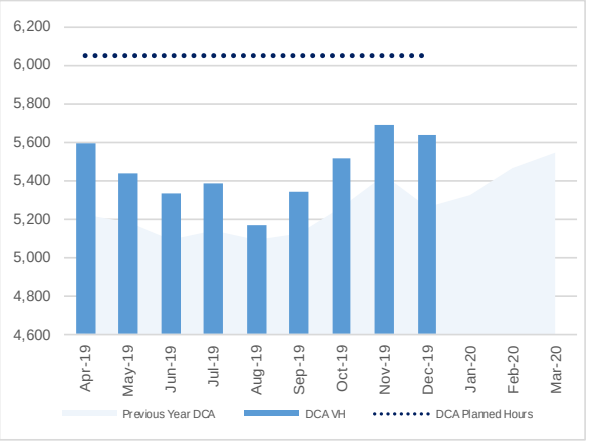
OOS HUB *- This account for out of service codes related to people/crew reasons for out of service hours*

OOS VRC *- This account for out of service codes related to vehicle reasons for out of service hours*

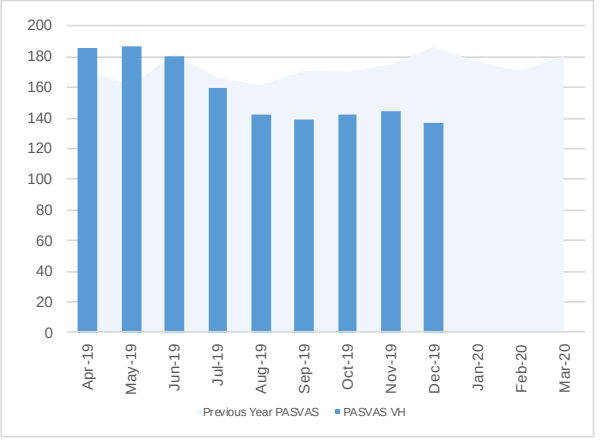
All Vehicles (Avg per day)



Ambulance Hours (Avg per day)



PAS / VAS (Avg per day)



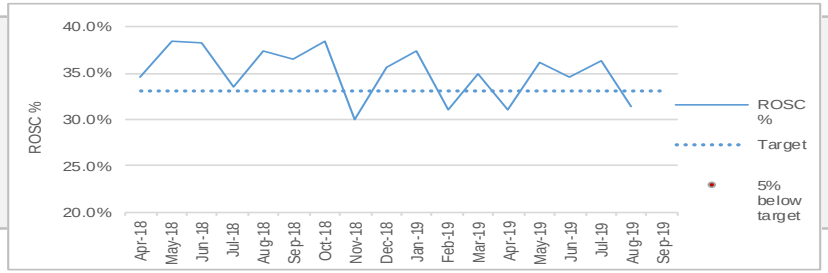
Clinical Ambulance Quality Indicators

Our Trust-wide scorecard covers four of the key Ambulance Quality Indicators: Cardiac Arrest - Return of Spontaneous Circulation (ROSC) at Hospital, Sepsis - Care Bundle, STEMI - Call to angiography and Stroke - Call to door. The data presented is from August 2019, which is the most recent month published by NHS England on 9th January 2020.

ROSC at Hospital

Month: 37.4%

Target: 33%



As with previous months, our rates of ROSC for cardiac arrest patients were above the national average for both the overall (31.4%) and Utstein (62.5%) groups.

Sepsis Care Bundle

Month: TBC

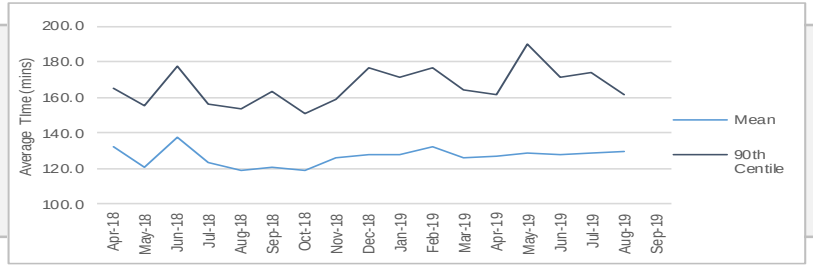
Target: TBC

NHS England did not publish Sepsis Care Bundle data for August, the next data due to be published will be for September (in February).

STEMI call to angiography

Mean: 02:08

Target: TBC

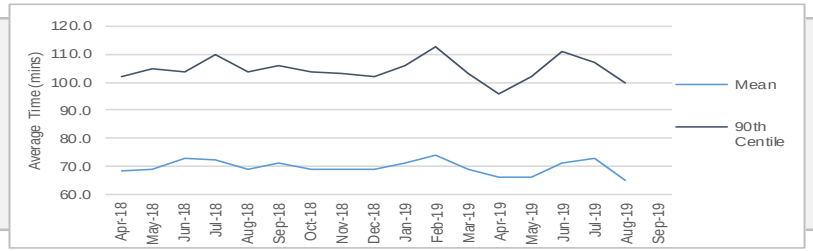


Our call to angiography time for STEMI patients was 02:10, slightly better than the national average of 02:11.

Stroke call to door

Mean: 01:05

Target: TBC



The LAS ranked best in class again for the mean call to hospital for suspected stroke patients (01:05) in August, the 4th time this financial year.

111 IUC Performance

Call answering performance for North East London (NEL) and South East London (SEL) over the past three months has under the target due to the financial recovery plan and review of the staffing model . Both SEL and NEL are within target for call abandonment and number of calls transferred to 999.

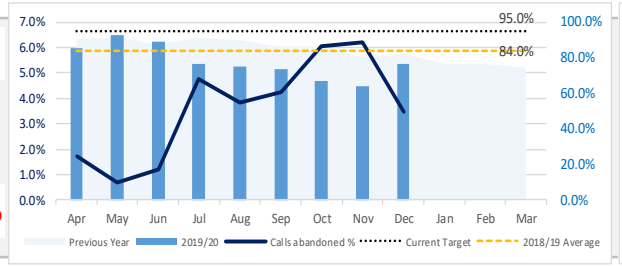
Call Answering & Abandoned Calls

SEL: 76.4% / 3.5%

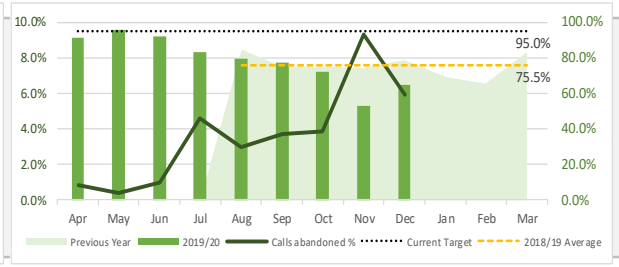
Target: 95% (CA) and 5%

NEL: 64.9% / 6.0%

South East London (SEL)



North East London (NEL)



The performance of 111/IUC services is critically important during bank holiday periods given the closure of some primary care services and are continually improving month on month.

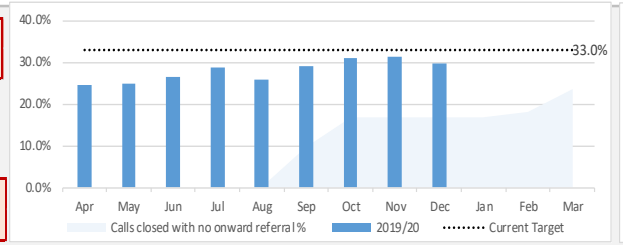
The number of calls abandoned by patients has fallen to the extent that we are now meeting our contractual standards against this metric.

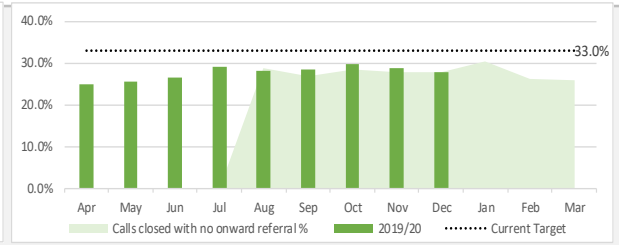
% of calls closed with no onward referral

SEL: 29.6%

Target: >33%

NEL: 27.7%





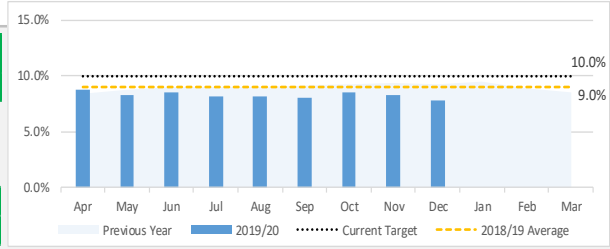
We are continuing to work to identify which patients benefit most from being managed via the CAS so that patients can have an advanced clinical assessment made and their care completed without onward referral. This significantly improves the quality of care provided over a standard 111 service and releases pressure on the wider healthcare system.

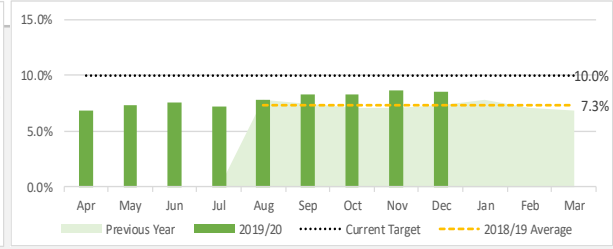
Calls Outcome: Transferred to 999

SEL: 7.8%

Target: <10%

NEL: 8.5%





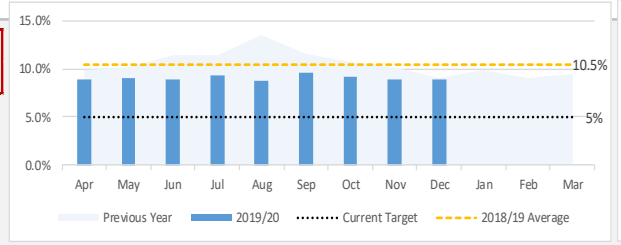
Referrals to 999 services remain within the 10% national standard for both NEL and SEL. During December, NEL delivered 8.4%, with SEL delivering 8.0%. This performance compares positively against the London average of over 10% and remains the lowest of all providers in London, indicating the benefits of a clinical assessment service (CAS).

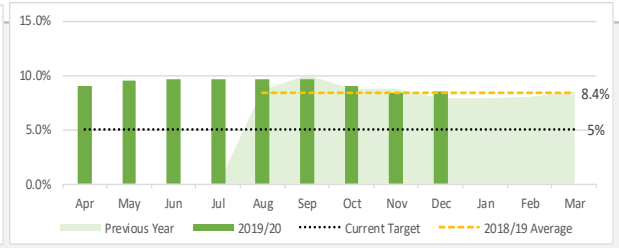
Call Outcome: Recommended to attend ED

SEL: 8.9%

Target: <5%

NEL: 8.5%





The development of our IUC services has enabled NEL and SEL to consistently outperform other providers in terms of A&E avoidance, however there is still a lot more work to do to minimize the recommendation for patients to attend A&E.

Business Plan Deliverables

Ref	Business Plan Deliverable	SRO	Status	Comment
BP.1	We will deliver our national performance and quality standards by optimizing our operational response model and delivering our operational plan	Khadir Meer / Pauline Cranmer	A	The 999 Operating Plan was approved by the ExCo on 7th August. The focus has now moved to delivering the plan which is targeting improved frontline performance through a combination of higher quality, efficiency and productivity initiatives. Progress against each of the workstreams (efficiencies, clinical response, people, vehicles) is being managed by the biweekly Operational Performance Group chaired by the interim Director of Emergency Ambulance Services. The works streams continue to be managed through their ADO leads, with central oversight from the Director of Ambulance Services. Of the 48 actions within the plan – 27 are recorded as closed (delivered or now as part BAU activity), 19 are Green (on track), 2 are Amber (at risk) and 0 are Red (off track).
BP.2	We will deliver our national 111 / IUC performance and quality standards through provision of an appropriate commissioned clinical decision support system and organisation of clinical teams in 111, 999 and Clinical Hub, to provide holistic clinical oversight, thereby making the best use of all available clinical resources.	Khadir Meer / Athar Khan	A	The IUC team have amalgamated three plans into one master plan. This plan covers; • Initial feedback from technical and restructure groups • Feedback from After Action Review • Action plan from Freedom to speak up concerns In addition to this we have agreed a minimum resourcing level, to provide clinical assurance within our financial envelope. The CAS resourcing is overseen by a senior CAS manager and ensures that clinical resourcing as a degree of rigour and compliance. We continue to work with commissioners to build a suitable reporting suite for future CAS metrics. As part of our winter preparations we have changed the resourcing plan which has resulted in better outturn in call handling and abandonment rate.

G Business Plan deliverable on track
A Business Plan deliverable off track but with plan in place to resolve issues
R Business Plan deliverable significantly off track
C Business Plan deliverable complete
Business Plan deliverable not started

BP.1 Performance and Quality standards Narrative:

The 999 Operating Plan was approved by the ExCo on 7th August. The focus has now moved to delivering the plan which is targeting improved frontline performance through a combination of higher quality, efficiency and productivity initiatives. Progress against each of the work streams (efficiencies, clinical response, people, vehicles) is being managed by the biweekly Operational Performance Group chaired by the interim Director of Emergency Ambulance Services.

The works streams continue to be managed through their ADO leads, with central oversight from the Director of Ambulance Services. Of the 48 actions within the plan – 27 are recorded as closed (delivered or now as part BAU activity), 19 are Green (on track), 2 are Amber (at risk) and 0 are Red (off track). This shows that a number of actions have been closed since the previous cut.

		Complete	G	A	R
Total	48	27	19	2	0

C Complete
G On track
A Off Track, will miss due date, with plan in place to resolve issues
R Irrecoverable, will miss/has missed due date

BP.2 IUC/111 Performance Narrative

The IUC team have amalgamated three plans into one master plan. This plan covers;

- Initial feedback from technical and restructure groups
- Feedback from After Action Review
- Action plan from Freedom to speak up concerns

In addition to this we have agreed a minimum resourcing level, to provide clinical assurance within our financial envelope. The CAS resourcing is overseen by a senior CAS manager and ensures that clinical resourcing as a degree of rigour and compliance. We continue to work with commissioners to build a suitable reporting suite for future CAS metrics.

IUC/111 Performance is overseen by BAF risk 54

IUC/111 improvement plan measures October 2019

Existing controls:

1. Daily monitoring of metrics including safety.
2. Executive oversight – direct reports meetings.
3. Thematic review of incidents and complaints weekly reflected in monthly quality report.
4. Revised forecast and planning modelling to improve resource productivity and capacity particularly at weekends.
5. Dashboards have been developed by F&P team to improve oversight and understanding of staffing required and these are having a significant impact in improving performance.
6. Scrutiny through both internal and external committees, QOG, QAG, CQRG.
7. Secured the support of regulators and commissioners in identifying further potential sources to recruit and retain medical staff within the CAS.
8. Additional capacity and capability engaged to assist in the delivery of the improvement plan.

Further actions:

1. The commissioning of a simulation software has been approved by ExCo which will enable a better understanding of staffing requirements and skill mix to achieve optimum performance and safety. The simulation is in it's final stages of completion.
2. Development of productivity measures to add to the performance score card to ensure oversight of productivity. We have now developed basic productivity measures and are looking at integrating telephony data to enhance them.

People Scorecard

December 2019

Indicator (KPI Name)	Frequency	Basis	Data From Month	Target Status	Current Perfomance: Target and Type (Internal / Contractual / National / All)		Current Perfomance: Latest Month	Current Perfomance: Year To Date (From April)	Current Perfomance: Rolling 12 Months	Trajectory: FY19/20 Trajectory	Benchmarking: National Data	Benchmarking: Best In Class	Benchmarking: Ranking (out of 11)
Staff Engagement Theme Score	Yearly	(n)	Mar-19		6.5	Internal	6.2						
Staff Survey Response Rate	Yearly	%	Dec-19		≥65%	Internal	72%						
Vacancy Rate (% of establishment)	Monthly	%	Dec-19		5%	Internal	2.7%	3.1%	3.5%				
Staff Turnover (% of leavers)	Monthly	%	Dec-19		10%	Internal	10.4%	11.7%	11.9%				
Equality, Diversity & Inclusion Theme Score	Annual	(n)	Mar-19		8.3	Internal	8.0						
BME Staff Engagement Theme Score	Yearly	(n)	Mar-19		6.4	Internal	6.1						
% of BME Staff	Quarterly	%	Dec-19		17.5%	Internal	16.0%	15.8%	15.7%				
Trust wide Staff Sickness levels (%)	Monthly	%	Dec-19		5%	Internal	5.4%	5.3%	5.3%				
Health and Safety (% of RIDDOR reports mtg <15day or less tgt)	Monthly	%	Dec-19		100%	Internal	85%	83%	82%				
MSK Related Staff Injuries (Staff Survey)	Yearly	%			<48%	National							
Rate of working days per 1,000 incidents lost due to MSK injuries	Monthly	(n)	Dec-19		2	Internal	0.87	3.11	3.17				
Bullying & Harassment (Safe Environment Theme)	Yearly	(n)	Mar-19		7.3	Internal	6.1						
Flu Vaccination Rate (Trust Total)	Monthly	%	Dec-19		75%	Internal	42.0%	42.0%	42.0%				
Statutory & Mandatory Training (85% or above)	Monthly	%	Dec-19		85%	Internal	84.4%	85.0%	84.0%				
Staff PDR Compliance (85% or above)	Monthly	%	Dec-19		85%	Internal	78.1%	78.9%	79.0%				
Improve leadership and management across the Trust (Visible and Engaging Leader Programmes - target of 36% of Trust Managers in 2019/20)	Monthly	(n/%)	Dec-19		36%	Internal	14.0%	14.0%	14.0%				
Level 3 Safeguarding Training Completed (90% target over 3yr period)	Monthly	%	Dec-19		800	National	75.1%	75.1%	75.1%				

- G — KPI on or ahead of target
- A — KPI off target but within agreed threshold
- R — KPI off target and outside agreed threshold
- KPI not reported / measurement not started

2. Our People

Vacancy Rates, Staff Turnover and Sickness (Trust Wide)

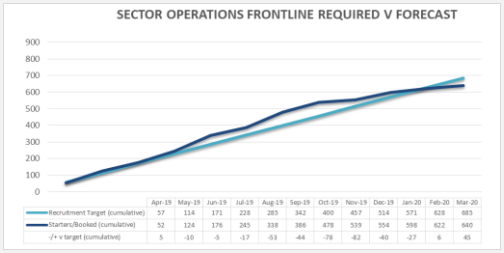
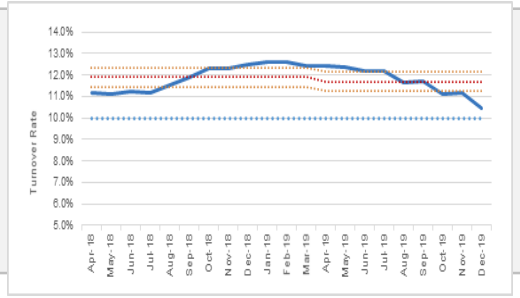
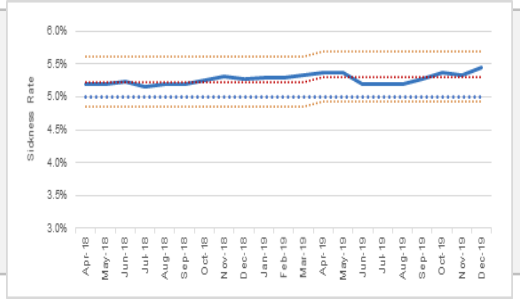
	Trust	Monthly Trend	Frontline	
Recruitment	Month: 0 FTE Target: 0 FTE		Required Frontline: 685FTE Forecast Supply:640FTE Forecast Gap: 45FTE	There are currently 252 iParas and 159 UK Paramedics (411) who have been allocated start dates and are expected to join the Trust between April 2019 and March 2020. The paramedic and TEAC recruitment is on plan with a forecasted year end position of 45fte vacancies (1.5%). For those available to be rostered (the 'in-ops' rate), we are forecasting a 4% gap at year end (140fte). Currently, the 'in-ops' vacancy rate for our frontline registered and non-registered staff is 3.4% (114fte vacancies). Planning for our 2020/2021 frontline requirements are underway which include the supply of 220fte Paramedics to the London Primary Care Networks from 2021/2022. Activities include a planned international trip to Australia in Q1, skype interviews and Band 5 TEAC recruitment.
Vacancy Rate	Month: 2.7% Target: 5%		All Frontline: 3.4% Paramedics: 1.1% EOC: 9.7%	Our overall vacancy rate is below target at 2.7%. EOC Recruitment – the recruitment pipelines are now in place to address turnover. This month we have not seen the expected number of leavers and the vacancy rate has remained at 10% (down from the forecasted 13%). This has improved our end of year forecast from 5.5% to 4.3% (12.3fte vacancies). The plan for 2020/21 is to recruit to 110% of the establishment and additional training capacity has been planned to deliver this. Overall 111 vacancy rate at 10.4% - Health Advisor and Clinical Advisor recruitment has had some success with starters in October and December. NETS recruitment is progressing well with an end of year vacancy forecast of 1-2%.
Staff Turnover	12 Month Rolling: 10.4% Target: 10%			Staff turnover rates have improved to 10.4%. We are one of the Trusts in the 5th Cohort National Retention Programme, a jointly led programme by NHSIE and NHS Employers. The programme offers trusts a range of support, which now forms an essential part of delivering the interim NHS People Plan and the NHS Long Term Plan. We met with the National team in November and have agreed an action plan with key deliverables in Q4. Locally, the international liaison team have met to review the feedback from our new international paramedic recruits and we have also agreed to fund any international paramedics who wish to apply for indefinite leave to remain. The one to one retention interviews with the international paramedics approaching their three year anniversary with the LAS have continued and this is helping to improve retention for this group. There still remains a challenge regarding the completeness of data for 'reasons for leaving' (why staff leave) and 'destination on leaving' (where do staff go) and this remains an area of concern and priority.
Sickness	12 Month Rolling: 5.3% Target: 5%			Trust wide staff sickness rates remain consistent with the previous 12 months at 5.3%. The work around the Occupational Health & Wellbeing scoping exercise has concluded and the next phase is to work with Procurement colleagues to develop the specifications. Work on the organisational flu programme continues with two thirds of staff having completed the on-line form (50% vaccinated, 17% have declined). All frontline areas have action plans in place to achieve an 80% compliance rate (forms completed) by 31st January 2020. The 'Out of Hours' immunisation service is now underway and in its first month delivered over 200 vaccines. Through the month of December, 30 Winter Wellbeing events took place, The Trust has secured access to the "HEADSPACE" mindfulness app for all staff and this initiative will commence in January. .

CHART KEY
- Monthly value
- Target
- Mean (Baseline FY17/18)
- Upper and Lower Limit (Baseline FY17/18)

Health and Safety

Compliance with Health and safety action plan:

Actions arising from the Health and Safety Review have been progressed in line with the action plan; 66/69 actions have been completed (and continue to be embedded) and 3 actions are in progress and on schedule/behind schedule.

Adverse Staff Events

*The total number of H&S incidents was 386 resulting in **3.76 events per 1000 A&E (face to face) incidents**. The breakdown of these events is shown in the analysis below.*

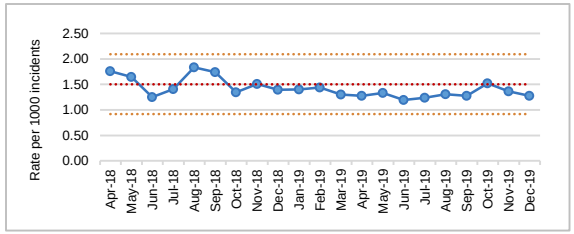
131 (34%) of the H&S related incidents reported during December - 2019 resulted in Low Harm.

9 (2%) of the H&S related incidents reported during December - 2019 resulted in Moderate Harm.

In line with the Trust Risk Management Strategy all RIDDOR incidents are graded as minimum moderate harm, this also aligns with the HSE RIDDOR requirements. This will help ensure management attention is focussed on proportionate interventions. (Hence the spike from April 2019).

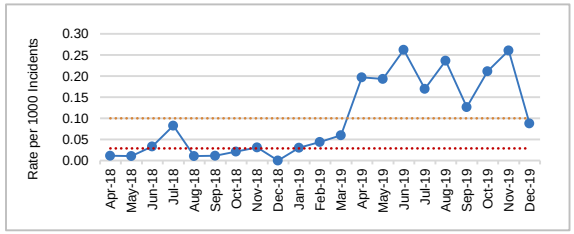
Month:1.28

Low Harm



Month: 0.09

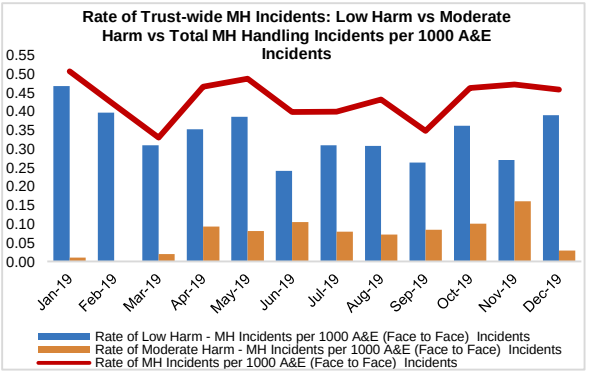
Moderate



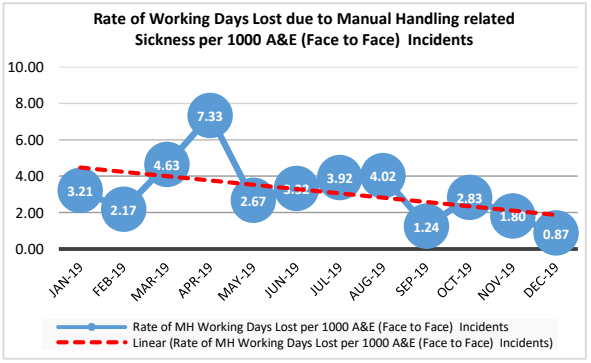
Manual Handling

- *Work to start on formalising Standard Operating Procedures, updating Risk Assessments and producing training aides for Moving and Handling Equipment in collaboration with frontline staff.*
- *The Manual Handling Steering Group is taking place and we are working towards agreeing the next years' MSK work plan.*

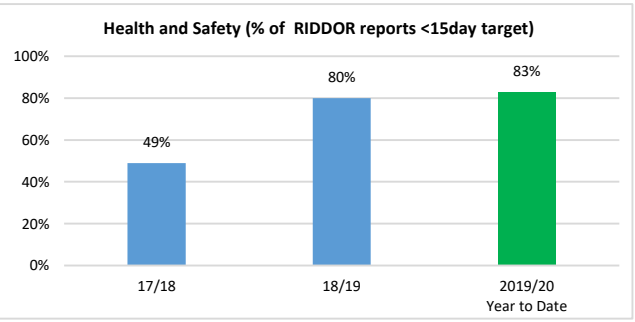
Manual Handling

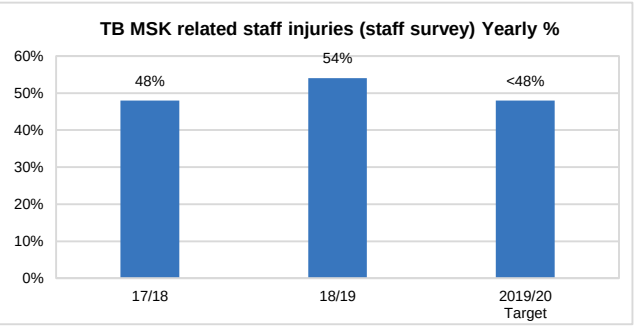


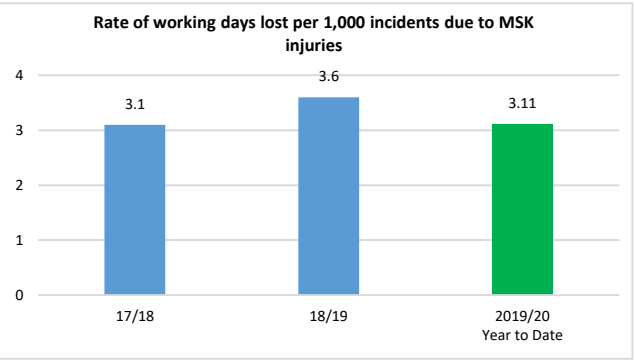
Manual Handling Related Sickness



New Indicator 2019/20





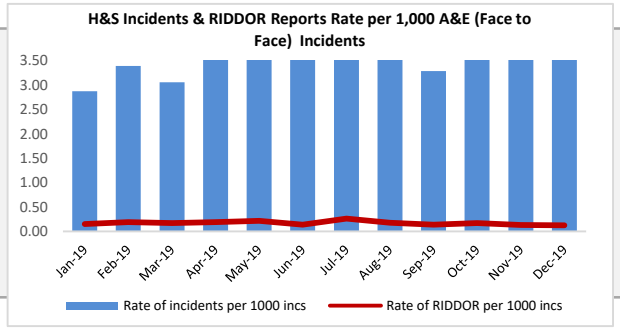


Health and Safety

The analysis below looks at 1) H&S Incidents rate & RIDDOR Report Rate *per 1000 A&E (face to face) incidents* 2) RIDDOR Incidents by Cause and 3) Assaults on Staff *:*

Rate of Incidents

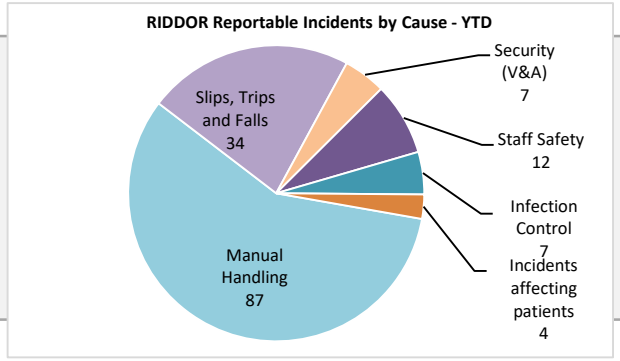
Monthly Trend



The graph on the left highlights the YTD rate of H&S and RIDDOR incidents per 1000 A&E incidents attended by the Trust.

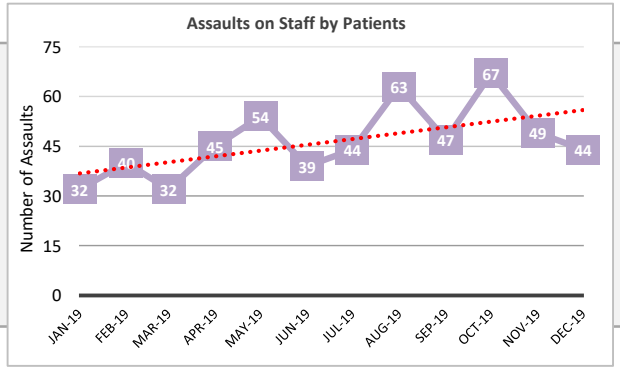
There is no benchmark/comparable data was received from any of the other ambulance Trusts during December 2019.

RIDDOR by Cause



- Total of 151 RIDDOR incidents reported to the HSE during 2019/20 (up to end of December'19)
- Total of 13 RIDDOR incidents reported to the HSE during December'19.
- 2 out of the 13 incidents reported outside the 15 days timeframe during December'19.
- The Trust wide RIDDOR reporting time frame (<15 days) compliance in December'19 was **85%.**
- Manual Handling & incidents account for the highest number of RIDDORs reported across the Trust during 2019/20 (up to end of December'19).

Assaults



There was a slight decrease in the number of assaults on staff by patient related incidents in December 2019 and the trend is downward.

The most common underlying causes remain: intoxication (drugs/alcohol), Mental Health related issues, patients recovering from fits/seizures or reacting to medication.

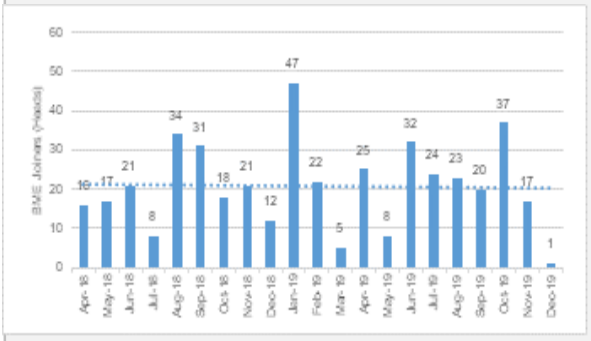
Additional Workforce Analysis

Ensuring that we try to build and retain a diverse workforce that is representative of the city of London is critical to our continued success. We must also ensure that our staff are properly trained and their performance regularly reviewed to ensure we support their development.

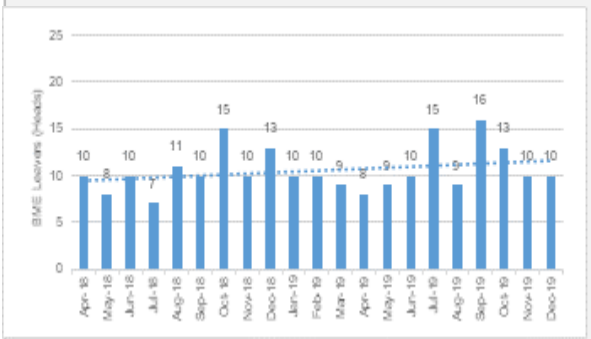
Equality, Diversity and Inclusion Standards

The LAS WRES action plan reports starters and leavers monthly and disciplinary and recruitment data quarterly. These graphs show the numbers of BME starters and leavers from April 2018 to September 2019 compared to the current Trust BME profile. During this period we have had 444 BME starters and 223 BME leavers, a net increase of 221. Overall numbers of BME staff continue to increase (currently 960) although this representation varies at different levels in the organisation.

BME Starters



BME Leavers



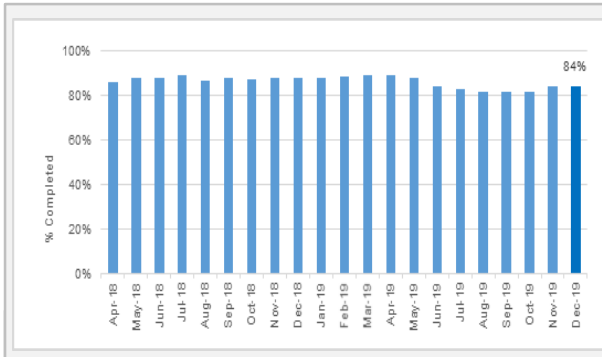
As part of the ongoing work with Health Education England to increase the number of BME students into Paramedic Science, Averil Lynch and Melissa Berry presented to the College of Paramedics quarterly meeting to discuss how they can work with the LAS to help work on the admission of increasing the number of BME students on to paramedic science. As a result of this there is to be a follow up meeting with Greenwich University, St Georges and Anglia Ruskin. The LAS hosted the National Ambulance Black and ethnic minority forum and discussed a number of key activities including the National Conference, a recruitment guide and 'Becoming a Culturally Intelligent and Inclusive Leader'. Our Chief Operating Officer Khadir Meer attended to meet the forum and will also attend the next meeting.

Statutory and Mandatory Training and Appraisals

Trust compliance in Statutory and Mandatory training is **84%.** Over 99% of our 6,020 substantive staff have logged into MyESR and 98% of this group have completed E-Learning. Over 4,000 E-Learning Courses were completed in December 2019 and 250,000 have been completed since our OLM go-live in September 2017.

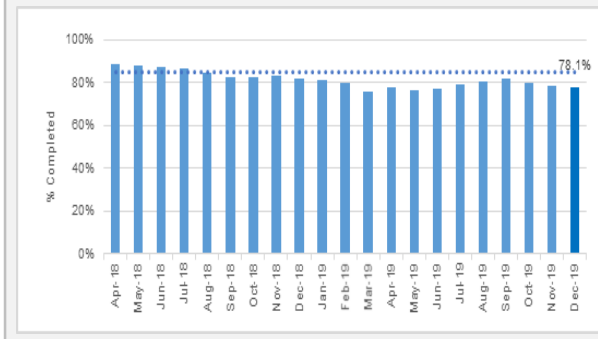
Appraisal completions at 78% at the end of December.

Statutory & Mandatory



Trust compliance is 84% with Operational teams at 84% and Corporate 89%. EOC, the subject of the CQC Must Do action, is at 89%. Information Governance is at 90.8% for December and will increase alongside CSR completions.

Appraisal Compliance



PDR Appraisals were at 78% at the end of December 2019. An improvement plan is being implemented for Corporate (73%) and Operational teams (79%) and weekly reports have been provided to Directors from June to facilitate the required improvement.

Appraisal Narrative

We started the 2019/20 year with an Appraisal compliance rate of 76%. This has stabilised and improved to 78% but is below target. An improvement plan is being implemented for Corporate and Operational teams and weekly reports are provided to Directors to facilitate the required improvement.

This will be formally brought to the ExCo on a quarterly basis.

Appraisal Position as at 31st December 2019

	2019/20										
	30-Apr	31-May	30-Jun	31-Jul	31-Aug	30-Sep	31-Oct	30-Nov	31-Dec	19/20 target	To complete
308 London Ambulance Service NHS Trust	77.4%	75.6%	76.6%	79.0%	80.5%	81.5%	79.3%	78.4%	78.1%	85.0%	-6.9%
308 Corporate L3	73.4%	76.4%	78.8%	78.3%	78.8%	81.9%	79.0%	75.9%	73.3%	85.0%	-11.7%
308 CHX Chief Executive L4	91.7%	83.3%	85.7%	100.0%	78.6%	100.0%	90.5%	88.9%	80.0%	85.0%	-5.0%
308 CORP Corporate Governance L4	91.7%	91.7%	91.7%	75.0%	84.6%	73.3%	75.0%	75.0%	80.0%	85.0%	-5.0%
308 SAP Strategic Assets & Property L4	16.5%	29.5%	38.1%	43.1%	48.2%	53.3%	66.2%	69.4%	69.4%	85.0%	-15.6%
308 FIN Finance L4	97.0%	100.0%	97.1%	88.6%	82.1%	69.2%	50.0%	52.0%	50.0%	85.0%	-35.0%
308 IM&T Information Management & Technology L4	92.1%	87.3%	86.9%	93.7%	88.2%	95.5%	78.9%	79.5%	74.0%	85.0%	-11.0%
308 MED Medical L4	86.1%	87.0%	88.2%	86.4%	86.9%	89.1%	85.1%	80.5%	76.8%	85.0%	-8.2%
308 NED Chairman & Non Executive L4	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	85.0%	-85.0%
308 PER Performance L4	93.3%	100.0%	100.0%	66.7%	83.3%	80.0%	81.8%	81.8%	75.0%	85.0%	-10.0%
308 P&C People & Culture L7	88.5%	90.5%	95.2%	88.9%	84.1%	87.9%	74.6%	61.2%	61.2%	85.0%	-23.8%
308 Q&A Quality & Assurance L4	96.8%	92.3%	91.0%	85.5%	93.0%	91.5%	87.2%	80.8%	79.7%	85.0%	-5.3%
308 S&C Strategy & Communications L4	76.0%	87.5%	82.6%	91.7%	83.3%	95.8%	100.0%	92.6%	88.0%	85.0%	3.0%
308 999 Operations L5	60.6%	64.7%	65.6%	68.7%	72.2%	72.1%	68.0%	65.5%	63.7%	85.0%	-21.3%
308 999 Emergency Operations Centre L6	63.9%	68.3%	69.7%	73.6%	79.3%	81.1%	76.7%	75.2%	72.1%	85.0%	-12.9%
308 111 & Integrated Urgent Care Services L5	52.3%	26.5%	27.3%	28.1%	43.0%	59.4%	65.5%	64.1%	63.9%	85.0%	-21.1%
308 ECS Emergency Care Services L5	82.0%	80.0%	81.0%	83.9%	84.5%	84.8%	83.1%	82.8%	83.3%	85.0%	-1.7%
308 RSA Resilience & Specialist Assets L6	86.4%	91.2%	90.6%	92.1%	89.1%	83.1%	77.8%	80.0%	80.3%	85.0%	-4.7%
308 ECS SEC North Central Sector L6	87.5%	88.0%	86.3%	84.1%	84.0%	83.1%	80.2%	80.1%	80.8%	85.0%	-4.2%
308 ECS SEC North East Sector L6	72.1%	72.6%	78.0%	83.6%	86.6%	88.9%	86.4%	86.2%	86.2%	85.0%	1.2%
308 ECS SEC North West Sector L6	81.6%	78.3%	81.2%	87.3%	85.7%	88.2%	88.6%	90.8%	90.2%	85.0%	5.2%
308 ECS SEC South East Sector L6	90.6%	87.8%	86.6%	88.1%	89.5%	89.3%	88.8%	86.6%	87.5%	85.0%	2.5%
308 ECS SEC South West Sector L6	82.1%	80.5%	79.0%	83.5%	84.3%	83.0%	79.8%	79.8%	80.4%	85.0%	-4.6%

Additional Workforce Analysis - Level 3 Safeguarding Training Completion

Background

1. Safeguarding Level 3 is now a National Requirement for all clinical staff as of the 1st April 2019

2. As at this date there are 4,816 staff who need to be trained.

3. We will be reporting and monitoring this from September when the Safeguarding team will have recruited additional trainers in post and additional training sessions will be rolled out from this point.

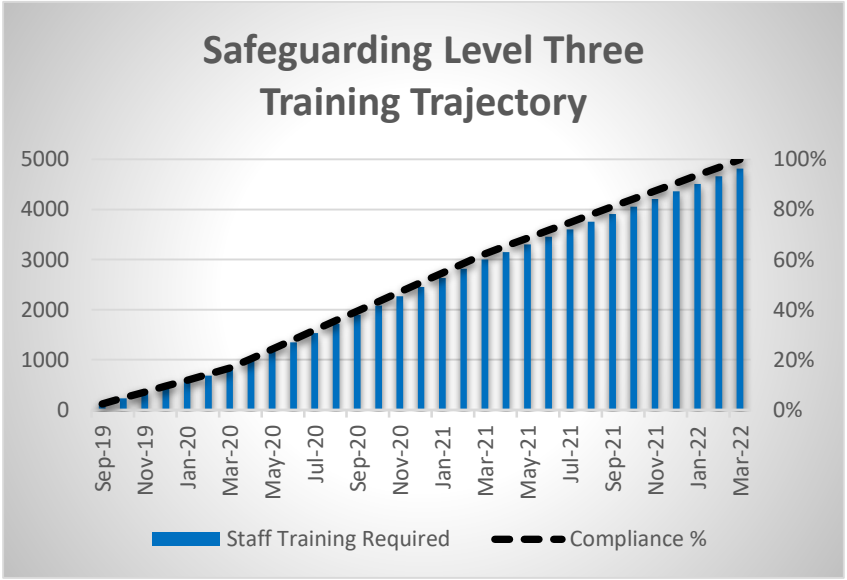
4. A training plan has been agreed with our Commissioners to deliver the training to all clinical staff by March 2022, and targets have been set for each of the years 2019/20, 2020/21 and 2021/22 as follows:

	Year Start	Year End	Compliance Target	% Completed
Year 1	Apr-19	Mar-20	800	17%
Year 2	Apr-20	Mar-21	3,000	62%
Year 3	Apr-21	Mar-22	4,816	100%

5. This is an additional requirement to the current 24 hour allowance for CSR training. Discussions are on-going to plan for this abstraction.

6. As at 31st December we have achieved a compliance rate of 14% against our March 31st 2020 target of 17%.

Safeguarding Trajectory



Business Plan Deliverables

Ref	Business Plan Deliverable	SRO	Status	Comment
BP.3	We will complete action plans across all functional and operational areas of the business to respond to the key issues identified in the 2018 Staff Survey and implement the planned actions in time for the 2019 Staff Survey.	Ali Layne-Smith		Work has been taking place across the organisation, both corporately and locally since the staff survey results were published in February 2019. Over 40 action plans have been developed by Staff Survey Champions based on local staff survey results and details of these were shared at the CEO roadshows. We had an excellent response to our Pulse Survey in Q1 which was an opportunity for staff to answer the 'Staff Friends and Family Test' questions and other staff survey questions. The 2019 survey was launched on 23rd September alongside the CEO roadshows. We achieved a response rate of 71.5%.
BP.4	We will complete the restructuring and recruitment of all Directorates to produce an efficient and lean organisation.	Ali Layne-Smith		Significant support is ongoing to some large scale organisational restructures including Finance, Logistics, Executive Restructure, EPMO and Quality.
BP.5	We will implement new business systems and technology to support more efficient and flexible ways of working and the wellbeing of our staff, enabling us to be more innovative in use of technology.	Ali Layne-Smith		This programme is on track and has so far seen delivery of the Employee Relations Case Management System, (which will enable stronger oversight of all Employee Relations cases and be able to track and monitor timescales and support lessons learnt), Non Payroll Workers (agency staff) on ESR (including 111 Agency Staff). Authority 2 Recruit E-Form – this went live as planned in July, replacing the Workforce Control Panel and Recruitment Authorisation Form. The GRS to ESR Absence Interface automatically populates ESR with absence information from GRS, replacing the current manual process. We are now able to report on Trust wide sickness absence reasons for the first time. There are 7 projects in Phase 3 of the Programme which are currently being managed through the ESR Programme Board: 1. P301 GRS to ESR Attendance Interface - Delivery 2. P302 ESR & OHIO Integration - Design 3. P303 Weekly Payroll - Scoping 4. P304 Digital HR Files - Scoping 5. P305 Management Hierarchy - Scoping commences in Apr-20 6. P306 Relocation Expenses - Scoping commences in May-20 7. P307 ESR Manager Self Service - Scoping commences in Jul-20 The ESR Programme Team are also supporting the synchronisation of ESR and Active Directory.
BP.6	We will continue to deliver our Workforce Race Equality Standard (WRES) Action Plan, and develop a response to the newly required Workforce Disability Quality Standard (WDQS) together with other measures, to improve diversity, inclusivity and equality across all areas of the organisation.	Ali Layne-Smith		The new format WRES Action Plan is well underway and the quarterly WRES Action Plan Group, chaired by the Director of People & Culture is bringing strong focus on driving this work forward. The action plan has senior nominated leads who will be involved in the delivery of the plan. The Trust has achieved its 18/19 target of 15% BME representation. Gender Pay results for 17/18 show an improvement in the bonus gap. The pay gap has remained at 5%. Workforce Disability Equality Scheme (WDES) standards - we have completed and submitted the national template and presented the progress report to the People & Culture Committee in October. The WDES is a set of specific measures (metrics) that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. This information will then be used to develop a local action plan, and enable the service to demonstrate progress against the indicators of disability equality.

Business Plan Deliverables

Ref	Business Plan Deliverable	SRO	Status	Comment
BP.7	We will improve the health and wellbeing of our staff, improving our occupational health service whilst also addressing health & safety issues to ensure both the physical and mental health of our staff created by high risk of trauma and stress.	Ali Layne-Smith		The work around the Occupational Health & Wellbeing scoping exercise has concluded and the next phase is to work with Procurement colleagues to develop the specifications. Work on the organisational flu programme continues with two thirds of staff having completed the on-line form (50% vaccinated, 17% have declined). All frontline areas have action plans in place to achieve an 80% compliance rate (forms completed) by 31st January 2020. The 'Out of Hours' immunisation service is now underway and in its first month delivered over 200 vaccines. Through the month of December, 30 Winter Wellbeing events took place, The Trust has secured access to the "HEADSPACE" mindfulness app for all staff. The initiative will commence in January.
BP.8	We will continue to implement our Clinical Education programme to deliver mandatory training and upskill our operational workforce.	Ali Layne-Smith/ Fenella Wrigley		Clinical education strategy workshop and alternative care pathway workshops have both been held. This, alongside the workforce planning workshop will enable the clinical education strategy to be completed.
BP.9	We will securely archive our existing student records and move to a digital student record management system for future training delivery following the CQC recommendations, mitigating the associated BAF risk.	Fenella Wrigley		Student records have been archived and moved to a secure facility. An electronic Student Management System has been procured and implementation has begun. This will ensure a single source of information for learners in programs, and many of the paper records will be transitioned to electronic files this year.
BP.10	We will roll-out training and development for all our leadership and management staff across functional and operational teams.	Ali Layne-Smith		Leadership development programme in delivery phase and Management Essential programmes also underway. The roll out of the Visible Leader and Engaging Leader programmes continue and both are planned for delivery across the remainder of this year and into next (for Engaging Leader) as we are training in excess of 800 managers across all roles in the organisation. This work is a pillar of the work to change our culture to align with our strategy and values. Continuous improvement will be built into the leadership development pathway elements as delivery progresses.

Public Value Scorecard

November 2019

Indicator (KPI Name)	Basis	Data From Month	Target Status	Current Perfomance: Target and Type (Internal / Contractual / National / All)		Latest Month Actual	Latest Month Plan	YTD Actual	YTD Plan	Rolling 12 Months	Outturn: FY19/20 Forecast	FY19/20 Plan	Benchmarking: National Data	Best In Class	Ranking (out of 11)
Control Total (Deficit)/Surplus	£m	Nov-19	A	0.024	A	1.347	0.338	(3.335)	(2.080)		0.024	0.024			
Performance Against Control Total	£m	Nov-19	A	100%	A						100%	100%			
Use of resources index/indicator (Yearly)	Rating	Nov-19	A	1	A	3	3	3	3	3	1	1			
% of Capital Programme delivered	%	Nov-19	A	100%	A	12%	7%	54%	70%		100%	100%			
Capital plan	£m	Nov-19	A	20.853	A	2.511	1.388	7.832	14.526		20.853	20.853			
Cash position	£m	Nov-19	G	15.1	A	22.3	20.0			21.4	15.1	15.1			
% spend against Agency Ceiling	%	Nov-19	G	92%	A	2%	8%	72%	67%		76%	92%			
CIP Savings YTD	£m	Nov-19	A	14.808	A	1.012	1.101	9.289	9.909		13.962	14.808			
	%	Nov-19	A	100%	A	92%		94%			94%	100%			
CIP Savings achieved - % Recurrent	£m	Nov-19	A	11.808	A	0.940	1.101	7.096	6.909		11.312	11.808			
	%	Nov-19	A	100%	A	85%		103%			96%				
Commercial income generation	£m	Nov-19	R	0.25	I	0	0	0	0		0	0.250			
Corporate spend as a % of turnover	%	Nov-19	A	<7.0%	I	12.3%	17.4%	16.6%	18.0%		17.0%	18.0%			
Cost per incident	£	Nov-19		£347	I						£ 332	£ 332			
Average Jobs per shift	%	Nov-19	G	5.3	I	5.5		5.5		5.3					

- G — KPI on or ahead of target
- A — KPI off target but within agreed threshold
- R — KPI off target and outside agreed threshold
- KPI not reported / measurement not started

CQUINs

The Commissioning for Quality and Innovation (CQUINs) payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. Details of the Trust's CQUINs is shown in the table below with details from the Q3 review to inform forecasted payments for the rest of the FY.

Urgent Care & Emergency Services CQUIN	Description	Weighting	Owner	CQUIN YTD	CQUIN Target	Total Value FY19/20	Predicted achievement	
Staff Flu Vaccinations	To improve the uptake of flu vaccinations amongst frontline healthcare workers with a target of 80% in 2019/20	0.25%	Fenella Wrigley	Q4	>80%	£843k	**£843k**	**100%**
Access to Patient Information – Assurance Process	Achievement of NHS Digital's assurance process for enabling access to patient information on scene, by ambulance crews via one of the four nationally agreed approaches i.e. SCRa (Q1, Q2, Q3 & Q4)	0.50%	Khadir Meer	Reporting is completed via NHS Digital		£1,687k	**£1,687k**	**100%**
Access to Patient Information – Demonstration	Achieving 5% of face to face incidents resulting in patient data being accessed by ambulance staff on scene. (Q3 & Q4)	0.25%	Khadir Meer	0.39%	>5%	£843k	**£843k**	**100%**
NHS Number reporting	To commence NHS Number reporting via the contractual MDS.	0.25%	Khadir Meer	Q4	>20%	£843k	**£843k**	**100%**
TOTAL		**1.25%**				**£4,213k**	**£4,213k**	**100%**

CQUIN achievement is guaranteed for 2019/20 as agreed as part of the contract settlement with commissioners.

CQUINs

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SEL IUC CQUIN	Description	Weighting	Owner	CQUIN YTD	CQUIN Target	Total Value FY19/20	Predicted achievement	
Calls answered in 60 seconds	Proportion of calls answered in 60 seconds	0.25%	Khadir Meer	**77.7%**	**>95%**	£22k	**£0k**	**0%**
Cat 3 & 4 ambulance revalidation	Proportion of calls initially given a category 3 or 4 ambulance disposition that are revalidated	0.25%	Khadir Meer	**76.9%**	**>80%**	£22k	**£18k**	**80%**
ED Disposition revalidation	Proportion of calls initially given an ED disposition that are revalidated	0.25%	Khadir Meer	**39.5%**	**>80%**	£22k	**£0k**	**0%**
Call back targets	Proportion of call back targets being met	0.25%	Khadir Meer	**95% across 7 priorities**		£22k	**£0k**	**0%**
Activity from External sources	Reporting and reviewing of activity originating from external sources e.g. 111 online and other 111 providers	0.25%	Khadir Meer	**Multiple targets**		£22k	**£11k**	**50%**
TOTAL		**1.25%**				**£110k**	**£29k**	**26%**

CQUINs

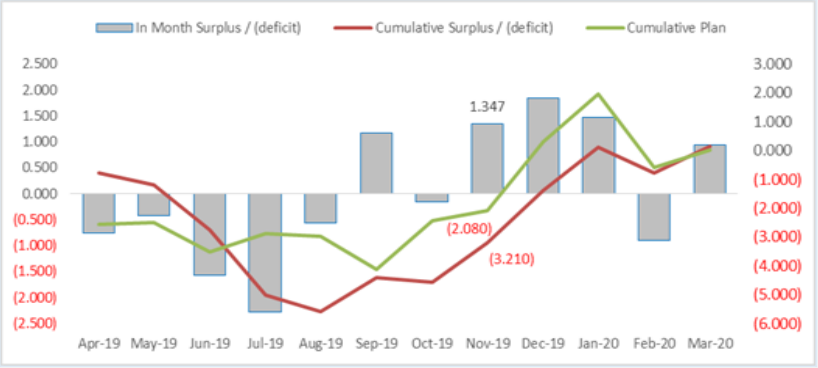
The Commissioning for Quality and Innovation (CQUINs) payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. Details of the Trust's CQUINs is shown in the table below with details from the Q3 review to inform forecasted payments for the rest of the FY.

NEL IUC CQUIN	Description	Weighting	Owner	CQUIN Target	Total Value FY19/20	Predicted achievement	
Staff Flu Vaccinations	Improving the uptake of flu vaccinations for all NEL IUC staff	0.50%	Fenella Wrigley	**> 75%**	£43k	**£22k**	**50%**
Calls closed as Self-Care	Measuring the total numbers of calls closed which do not require onward referral, reducing pressure on the wider health service.	0.38%	Khadir Meer	**>33%**	£32k	**£16k**	**50%**
Referrals & Management of Patients within the CAS*	To promote hear and treat to support enhanced clinical decision making and avoid unnecessary A&E attendances and subsequent admission.	0.38%	Khadir Meer	**95% across 7 priorities**	£32k	**£0k**	**0%**
TOTAL		**1.25%**			**£108k**	**£38k**	**35%**

Trust Financial Position and Contract Position

The full year outturn for the Trust is £25k surplus which is on plan to meet our control total. The month ended with a strong cash position of £22.3m.

YTD outturn vs budget



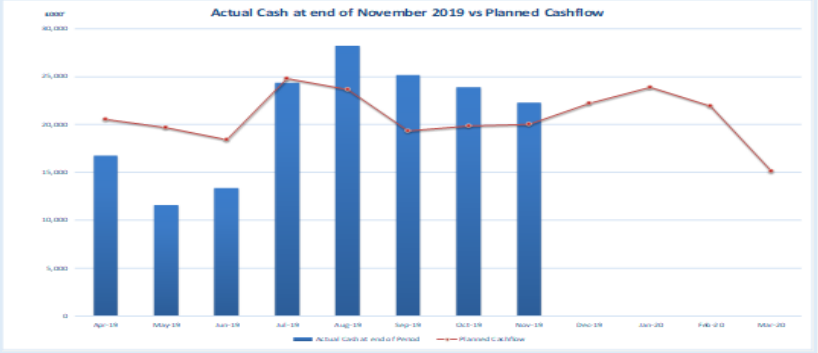
- **YTD position:** At month 8 of £3.3m deficit (£3.2m net of 18/19 CQUIN), £1.2m adverse to plan.
- **Full year forecast:** At month 8 full year forecast is £25k surplus, which is in line with plan. The month 8 full year forecast position prior to required technical adjustments is £2.7m deficit, which is a deterioration from the month 6 forecast of £2.9m (m6 forecast delivered the control total of £25k surplus without the need for any technical adjustments)
- **Risks**: Delivery of the control total will require successful mitigation of identified expenditure risks, specifically reducing the run-rate on IUC clinical triage costs and frontline pay costs in line with what is currently included in the forecast

Financial Position Metrics

	YTD		Full year	
	Plan	Actual	Plan	Actual
Capital service cover rating	1	1	1	1
Liquidity rating	2	1	1	1
I&E margin rating	4	4	2	2
I&E margin - distance from plan	n/a	1	n/a	1
Agency rating	1	2	1	1
Overall rating	3	3	1	1

- **Use of Resources:** NHSI rates Trust's on a Use of Resources rating. The scoring system ranks from '1' (low risk/best score) to '4' (high risk/worst score). The table left shows the Trust's Use of Resources rating for YTD to month 8 and full year forecast. The Trust's YTD rating is a 3 due to the I&E margin rating being 4, which is in line with the submitted plan. This is driven by the profiling of contract income being weighted to Q4 to reflect the planned activity profile
- **Capital**: YTD capital spend of £7.8m, which is £6.7m behind plan. The Trust reprioritised schemes across its capital portfolio in month 7. Month 8 expenditure is £2.5m, significantly above previous monthly run-rate and in line with the revised forecast. Schemes have been reprioritised and are being managed through the Enterprise Programme Management Office and reviewed at Portfolio Management Board

Cash position



- **Cash:** Cash is £22.3m as at 30 November 2019, £2.3m above plan. The main reason for the favourable position is the under spend on capital and provisions being offset by higher than expected pay (re-banding of ambulance crews) and non-pay expenditure. Cash is forecast to be £20.8m as at 31 March 2020, £5.7m above plan. The main reason for the favourable position is improved year-end debtor balances and the under spend on provisions being offset by higher than expected pay (re-banding of ambulance crews) and non-pay expenditure
- **Better Payment Practice Code**: The government has set a target that organisations should aim to pay 95% their supplier invoices within 30 days. The NHS and Non-NHS performance by volume for November 2019 was 97.2% and 96.3% respectively. The Trust has a high volume of overdue invoices waiting to be approved and Directorate managers and staff have been sent lists of invoices that are outstanding that require approval.

Our Statement of Comprehensive Income reports the Trust's financial performance over a specific accounting period. Financial performance is assessed by giving a summary of how the Trust incurs its income and expenses through both operating and non-operating activities. It also shows the net surplus or deficit incurred over a specific accounting period.

Statement of Comprehensive Income (Month 8 – November 2019)

	Month 8 2019-20 £000			YTD Month 8 2019-20 £000			Full Year 2019-20 £000		
	Budget	Actual	Variance fav/(adv)	Budget	Actual	Variance fav/(adv)	Budget	Full Year Forecast Month 8 2019-20	Variance to budget fav/(adv)
Income									
Income from Activities	33,391	34,188	796	263,008	269,939	6,931	397,937	409,099	11,162
Other Operating Income	636	837	201	3,365	4,770	1,405	6,418	8,130	1,712
Total Income	**34,027**	**35,024**	**997**	**266,373**	**274,710**	**8,336**	**404,355**	**417,229**	**12,874**
Operating Expense									
Pay	(25,115)	(25,444)	(329)	(199,028)	(202,945)	(3,917)	(299,422)	(301,838)	(2,415)
Non Pay	(6,894)	(6,662)	232	(55,992)	(62,017)	(6,025)	(83,943)	(94,236)	(10,293)
Total Operating Expenditure	**(32,009)**	**(32,106)**	**(97)**	**(255,020)**	**(264,961)**	**(9,942)**	**(383,365)**	**(396,074)**	**(12,709)**
EBITDA	**2,018**	**2,919**	**900**	**11,354**	**9,748**	**(1,605)**	**20,990**	**21,155**	**165**
EBITDA margin	5.9%	8.3%	2.4%	4.3%	3.5%	(0.7%)	5.2%	5.1%	(0.1%)
Depreciation & Financing									
Depreciation & Amortisation	(1,298)	(1,181)	118	(10,395)	(9,879)	516	(16,400)	(16,400)	0
PDC Dividend	(388)	(388)	0	(3,104)	(3,104)	(0)	(4,656)	(4,656)	0
Finance Income	8	19	10	83	109	26	117	146	29
Finance Costs	(2)	(3)	(0)	(18)	(44)	(26)	(27)	(54)	(27)
Gains & Losses on Disposals	0	(18)	(18)	0	(41)	(41)	0	(41)	(41)
Total Depreciation & Finance Costs	**(1,680)**	**(1,571)**	**109**	**(13,434)**	**(12,958)**	**475**	**(20,966)**	**(21,005)**	**(39)**
Remove STP funding 2018/19	0	0	0	0	(125)	(125)	0	(125)	(125)
Net Surplus/(Deficit)	**338**	**1,347**	**1,009**	**(2,080)**	**(3,335)**	**(1,255)**	**24**	**25**	**1**
NHSI Adjustments to Fin Perf									
Remove Depr on Donated assets	3	3	(1)	25	24	(1)	38	35	(3)
Adjusted Financial Performance	**341**	**1,350**	**1,009**	**(2,055)**	**(3,311)**	**(1,256)**	**62**	**60**	**(2)**
Net margin	1.0%	3.8%	2.9%	(0.8%)	(1.2%)	(0.4%)	0.0%	0.0%	0.0%

YTD position

YTD position for the Trust is £3,335k deficit inclusive of PSF (excluding 18/19 STP funding), which is £1,255k behind plan. Key drivers of this position are:

- A&E contract income £5,761k above plan due to activity over performance (based on the revised contract of £373m which is full year over performance of £5m) and additional YTD income to support recurrent workforce cost pressures that have arisen in year e.g. Emergency Ambulance Crew pay uplift, holiday pay overtime
- Other operating income £1,405k favourable to plan driven by apprenticeship income, training & education funding and stadia & events income
- Realisation of £1.8m of additional CIPs that are awaiting to be formally signed-off
- Pay overspend, excluding the workforce cost pressures identified above, of £1,184k. This driven by costs of delivering increased 999 activity (£3,631k) offset by vacancies across non-frontline operations teams (£2,447k)
- £4,301k spend, for which there is no budget, on managed services and GP costs relating to the cost of delivering safe levels of performance within IUC
- £655k overspend on transport costs, driven by the cost of private ambulance to support frontline operations deliver higher levels of activity being offset by lower fuel, insurance and leasing costs
- £1,538k overspend on non-pay costs relating to frontline staff (subsistence, travel, uniforms)
- £516k underspend in depreciation driven by slippage in the capital programme

Full Year forecast

The full year forecast position is £150k surplus (£25k surplus excluding 18/19 STP funding), which is on plan. Delivery of this forecast position is currently predicated on technical adjustments of £2,877k. Key variances in the forecast position align to those as described in the YTD narrative above:

- A&E contract income £8,875k above plan
- Other operating income £1,712k favourable to plan
- Pay overspend of £2,415k, driven by frontline operations overspend of £6,234k offset by non-frontline underspend of £3,818k
- Managed services and GP costs relating to IUC/111 of £7,029k
- £913k overspend on transport costs
- £1,032k overspend on non-pay costs relating to frontline staff (subsistence, travel, uniforms)

Our Cashflow Statement summarises the amount of cash and cash equivalents entering and leaving the Trust. It measures how well the Trust manages its cash position, meaning how well the Trust generates cash to pay its debt obligations and fund its operating expenses.

Cashflow statement (Month 8 – November 2019)

	May-19 Actual	Jun-19 Actual	Jul-19 Actual	Aug-19 Actual	Sep-19 Actual	Oct-19 Actual	Nov-19 Actual	Nov-19 YTD Move	Nov-19 YTD Plan	Nov-19 Var
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Opening Balance	**16,799**	**11,622**	**13,359**	**24,366**	**28,250**	**25,165**	**23,902**	**21,718**	**21,718**	**0**
Operating Surplus	1,360	185	(767)	945	2,715	1,403	2,918	9,749	9,996	(247)
(Increase)/decrease in current assets	(4,789)	1,317	11,038	2,939	(5,311)	789	(1,592)	2,611	11,059	(8,448)
Increase/(decrease) in current liabilities	(1,498)	482	213	270	2,005	(1,364)	(1,876)	(2,915)	1,124	(4,039)
Increase/(decrease) in provisions	235	355	428	214	68	(69)	87	1,540	(6,650)	8,190
Net cash inflow/(outflow) from operating activities	(4,692)	2,339	10,912	4,368	(523)	759	(463)	10,985	15,529	(4,544)
Cashflow inflow/(outflow) from operating activities	**(4,692)**	**2,339**	**10,912**	**4,368**	**(523)**	**759**	**(463)**	**10,985**	**15,529**	**(4,544)**
Returns on investments and servicing finance	14	10	0	7	23	11	19	84	82	2
Capital Expenditure	(499)	(612)	95	(491)	(431)	(2,033)	(1,133)	(8,308)	(15,000)	6,692
Dividend paid	0	0	0	0	(2,154)	0	0	(2,154)	(2,328)	174
Financing obtained	0	0	0	0	0	0	0	0	0	0
Financing repaid	0	0	0	0	0	0	0	0	0	0
Cashflow inflow/(outflow) from financing	**(485)**	**(602)**	**95**	**(484)**	**(2,562)**	**(2,022)**	**(1,114)**	**(10,378)**	**(17,246)**	**6,868**
Movement	(5,177)	1,737	11,007	3,884	(3,085)	(1,263)	(1,577)	607	(1,717)	2,324
Closing Cash Balance	**11,622**	**13,359**	**24,366**	**28,250**	**25,165**	**23,902**	**22,325**	**22,325**	**20,001**	**2,324**

Operating Position

- There has been a net inflow of cash to the Trust of £0.6m, this is £2.3m higher than the planned outflow (£1.7m)
- Cash funds at 30 November stand at £22.3m
- The operating surplus at £9.7m is £0.2m below plan

Current Assets

- The movement on current assets is £2.6m, (£8.4m) lower than the planned movement
- Current assets movement was due to receivables £4.4m, accrued

Current Liabilities

- The movement on current liabilities is (£2.9m), a (£4.0m) lower than planned movement
- Current liabilities movement was lower than planned due to trade and other payables (£4.7m), accruals (£0.4m) and Deferred income £1.1m

Provisions

- The movement on provisions is £1.5m, is a £8.2m higher than planned movement. £4.8m of this movement is related to a technical adjustment to the accounts that occurred after the plan was submitted

Cost Improvement Programmes (CIPS) and Capital Plan

To prepare our Trust for the future we need to ensure we manage our costs effectively and where possible reduce the costs of running the Trust whilst maintaining the absolute best care for our patients. We also need to strategically invest year on year in our estate, fleet and technology capability so that we can continue to offer a world-class ambulance service.

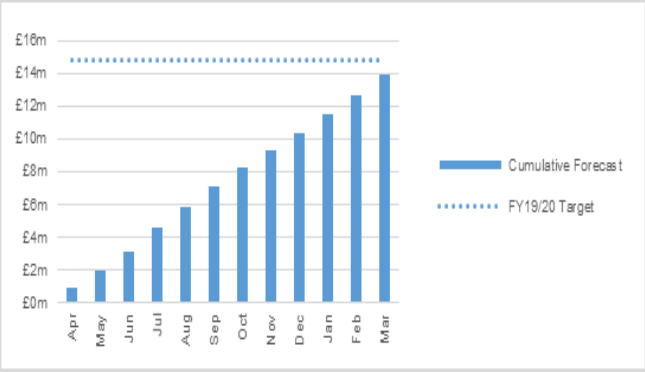
Cost Improvement Programmes (CIPS)

- The Trust is forecasting £14.0m delivery against its £14.8m CIP target in 2019/20. This £0.8m shortfall is being mitigated through additional savings identified as part of in-year financial recovery
- Of the £14.0m forecast, 81% is recurrent delivery

CIP Savings

FY Forecast: £14.0m

FY Target: £14.8m

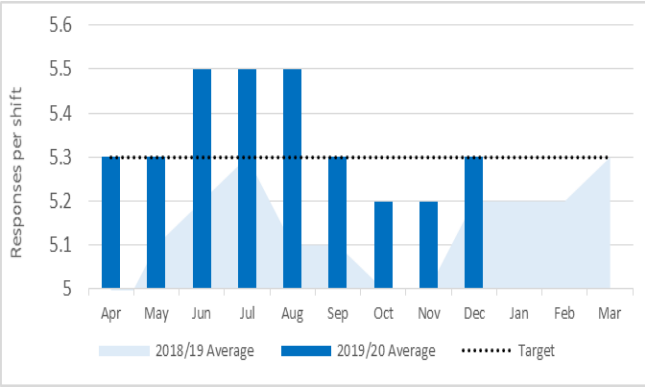


Jobs per shift (DCA)

Average jobs per 12 hour shift

Actual: 5.3

Target: 5.3



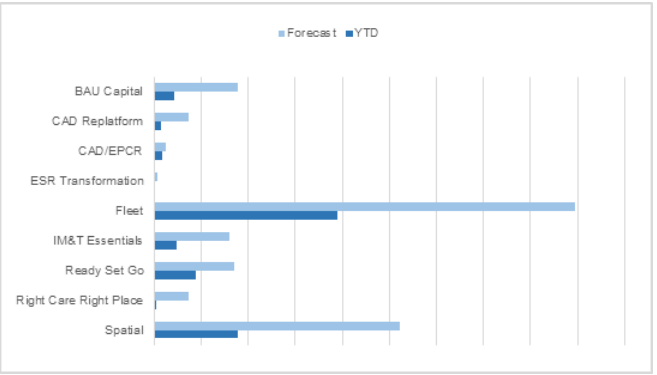
Capital Plan

- YTD Capital spend is £7.8m against a plan of £14.5m, £6.7m behind plan
- With the recently confirmed position that the Trust will have its full original capital plan of £20.8m, the Trust is in the process of reprioritising schemes that had been deferred. The Trust is forecasting full delivery against the plan

Capital Plan Breakdown

YTD: £7.8m

FY Plan: £20.8m



Operations are tracking the performance of jobs per shift on a monthly basis and are consistently hitting the agreed target. While there is no programme of work focusing solely on this metric, a number of our efficiency and productivity schemes will impact this number. For example success in improving Handover to Green times and reducing OOS CIPs would improve the Jobs per shift measure

Business Plan Deliverables

Ref	Business Plan Deliverable	SRO	Status	Comment
BP.11	We will deliver our control total and maintain our use of resources rating with NHSI.	Lorraine Bewes		Delivery of the Trust Control total remains at risk, due to a combination of factors. The Trust has developed a Financial Recovery Plan which is currently being implemented
BP.12	We will establish a new approach for the contract with commissioners and STPs, by incentivisation of behaviours that improve outcomes for our patients whilst providing better support for the London's health system.	Lorraine Bewes		A revised forum for consideration of future contracting / commissioning arrangements is being established. A range of potential options for discussion are being developed. In parallel the Trust has engaged with the regional regulator to realise a new model of integrated urgent care delivery
BP.13	We will deliver and share visibility with commissioners of our Cost Improvement Programme (CIP) efficiency savings in 2019/20 whilst developing further efficiencies to inform the 5Yr STP Plans.	Lorraine Bewes		The Trust is forecasting £14.0m delivery against its £14.8m CIP target in 2019/20. This £0.8m shortfall is being mitigated through additional savings identified as part of in-year financial recovery. Of the £14.0m forecast, 81% is recurrent delivery
BP.14	We will rationalise our corporate, operations and training estate making best use of digital technology to improve existing space, and ensuring our facilities and estate enables flexible working.	Justin Wand		The Trust is progressing a twin approach for both operations and corporate estate. The former is being addressed by guidelines around the future Estates configuration, whilst the latter is work in progress – introducing 7:10 ratio at Waterloo and Pocock St. alongside the closure of Morley Street in year and Union Street at end of financial year.
BP.15	We will identify new commercial opportunities to generate additional income of £1m for the Trust by 2022. We will review a range of areas including provision of training and utilisation of sponsorship opportunities.	Lorraine Bewes		The new Head of Commercial role is now in place. The role is developing a range of new income options, as well as supporting procurement to review how LAS can get best value from existing contracts. However, identified opportunities will need to be adequately scoped and as such only likely to deliver from 20/21 onwards
BP.16	We will modernise and manage our fleet with new driver safety and security systems, whilst introducing engineering quality standards within the workshops, and in parallel ensuring all our vehicles meet the requirements of London's Ultra Low Emission Zone (ULEZ) before exemption period is complete.	Justin Wand		Business case for Driver safety system and Asset management is to be presented to Portfolio Mgt Board on 4th Sept with required updates. A proposal for a procurement model has been completed and is subject to approval by ExCo.

Partners Scorecard

December 2019

Indicator (KPI Name)	Basis	Data From Month	Target Status	Target and Type (Internal / Contractual / National / All)		Latest Month	Year To Date (From April)	Rolling 12 Months	FY19/20 Trajectory	National Data	Best In Class	Ranking (out of 11)
				Current Perfomance					Trajectory	Benchmarking (Month)		
Hospital handover	minutes	Dec-19	R	18.5	I	23.7	20.4	20.5				
Post-handover (Handover 2 Green)	minutes	Dec-19	G	16.0	I	15.3	15.4	15.4				
See and Convey – to ED (Contractual Position) **	%	Dec-19		58.25%	C	55.8%	57.8%	58.2%		56.8%	51.9%	7
Hear and Treat % **	%	Dec-19		7.9%	C	8.1%	7.2%	7.2%		7.4%	10.7%	5
Savings delivered to wider urgent & emergency care system through management of IUC services (£m) – Still being developed	£m			TBC		This metric has proved difficult to ascertain in a way that can be tracked on a regular basis. As part of the long term financial plan development we are refreshing our strategy modelling over July and August and the specifics for this metric will come out of that work in a way that can be tracked on a regular basis through the IPR.						
CQC rating - Overall	Annual Rating			O / S	N	TBC	Awaiting CQC Inspection					
CQC rating - Well-led	Annual Rating			G	N	TBC						
Cyber Essentials Plus Accreditation	%	Sep-19		100				TBC				

**LAS have agreed to a 1% (pan-London) ED Conveyance Reduction and an increase in H&T of minimum 3,500 on last year's baseline.

Benchmarking Key
Top 3
Ranked 4-7
Ranked 7+

Please note:

999 performance data is correct as at 08/01/20 and is subject to change due to data validation processes

G	KPI on or ahead of target
A	KPI off target but within agreed threshold
R	KPI off target and outside agreed threshold
	KPI not reported / measurement not started

4. Our Partners

Maximising safe non-conveyance to ED

Our operational efficiency is critical to our success and whilst one of our key dependencies is the ability to successfully handover if a patient is conveyed to hospital we must ensure we strive to be as efficient as possible whilst always delivering the very best care for our patients.

Please note:
999 performance data is correct as at 08/01/20 and is subject to change due to data validation processes

Arrival at Hospital to Patient Handover

We almost a double number of delays in December, compared to September, with the overall number of hours lost going up by ~2,200 hours lost from our arrival to patient handover over 30 mins. King Georges, Queens Romford and North Middlesex had the greatest proportion of handovers exceeding 30 minutes. Northwick park had the had the highest number of lost hours over 30 minutes, at 604 hours for the month.

STP	Hospital	Total Conveyances	Handovers	Handovers Exceeding 30 mins	% of Handovers over 30 mins	Total Time Lost Over 30 Mins	Average Arr at Hosp to Patient Handover Time
North Central	Barnet	1,712	1,622	466	29%	184.9	28.6
	North Middlesex	2,559	2,417	861	36%	216.5	15.8
	Royal Free	1,685	1,558	354	23%	116.5	16.5
	University College	1,929	1,805	294	16%	85.9	27.5
	Whittington	1,505	1,406	215	15%	61.3	20.1
North East	Homerton	1,471	1,393	23	2%	1.7	18.7
	King Georges	1,273	1,182	577	49%	158.2	13.5
	New ham	2,108	1,903	367	19%	41.3	33.9
	Princess Royal	1,708	1,558	374	24%	310.3	25.3
	Queens Romford	2,863	2,693	1,264	47%	546.6	19.1
	Royal London	2,255	2,097	163	8%	10.4	27.8
	Whipps Cross	1,953	1,839	494	27%	187.2	22.7
North West	Charing Cross	1,287	1,212	25	2%	1.8	28.1
	Chelsea & West	1,479	1,367	58	4%	10.3	34.6
	Ealing	1,552	1,439	225	16%	50.9	30.2
	Hillingdon	2,067	1,926	260	13%	89.9	15.1
	Northw ick Park	2,766	2,565	893	35%	604.8	**37.3**
	St Marys	1,987	1,866	299	16%	40.8	24.4
	West Middlesex	2,215	2,117	62	3%	7.3	17.7
South East	Kings college	2,162	1,969	492	25%	143.5	27.7
	Lew isham	1,498	1,379	328	24%	174.1	23.5
	Queen Elizabeth II	2,481	2,390	127	5%	93.7	21.5
	St Thomas'	2,582	2,433	105	4%	7.8	16.8
South West	Croydon	2,138	2,036	484	24%	200.2	21.4
	Kingston	1,691	1,554	55	4%	29.7	14.9
	St Georges	2,021	1,883	599	32%	161.1	27.3
	St Helier	1,312	1,259	177	14%	78.4	20.5
	TOTAL	52,259	48,868	9,641	20%	**3,615**	23.7

Max average breach value
Value >10 mins per breach

Patient Handover to Green

In December, we saw a strong handover to Green performance with 15.3. However, Over 4,400 hours were lost due to patient handover to green exceeding the 14 minute threshold. There is organisational focus as well as a cost improvement programme to recover this situation with action plans focusing on clarification of targets, improving the process and sharing good practice across sector.

Sector	Station Group	Handovers to Green	Handovers Exceeding 14 mins	% over 14 mins	Total Time Lost (hours)	Avg Time PH to Green	90th Centile PH to Green	Avg mins lost per breach
North Central	Camden	2,737	1,439	53%	226.7	15.3	28.9	9.5
	Edmonton	3,605	1,833	51%	298.7	15.5	29.6	9.8
	Friern Barnet	2,434	1,295	53%	183.3	15.4	28.0	8.5
North East	Homerton	3,396	1,905	56%	275.8	15.7	28.7	8.7
	New ham	4,809	2,745	57%	427.7	15.5	30.4	9.3
	Romford	4,156	2,241	54%	287.8	15.1	25.9	7.7
North West	Brent	4,171	2,203	53%	372.5	15.9	29.8	10.1
	Fulham	2,930	1,607	55%	253.1	16.4	30.2	9.4
	Hanw ell	3,373	1,711	51%	204.0	14.4	25.6	7.2
	Hillingdon	2,055	1,141	56%	160.6	15.9	28.0	8.4
	Westminster	1,992	1,079	54%	159.9	15.6	27.0	8.9
South East	Training	2,174	1,023	47%	139.1	14.5	27.6	8.2
	Bromley	2,450	1,440	59%	211.2	15.9	30.2	8.8
	Deptford	5,497	3,088	56%	466.2	16.1	30.0	9.1
South West	Greenw ich	3,150	1,734	55%	227.5	16.3	29.8	7.9
	Croydon	2,438	1,474	60%	183.6	15.8	27.2	7.5
	New Malden	1,742	950	55%	135.4	15.7	29.8	8.6
	St Helier	1,521	844	55%	90.8	14.7	24.2	6.5
Other	NULL	363	177	49%	28.0	16.0	29.8	9.5
	IRO	11	8	73%	6.1	24.0	86.8	**45.8**
	NETS	702	251	36%	25.9	5.2	18.8	6.2
	Other	698	421	60%	105.7	15.3	35.4	15.1
	Training	2,174	1,023	47%	139.1	14.5	27.6	8.2

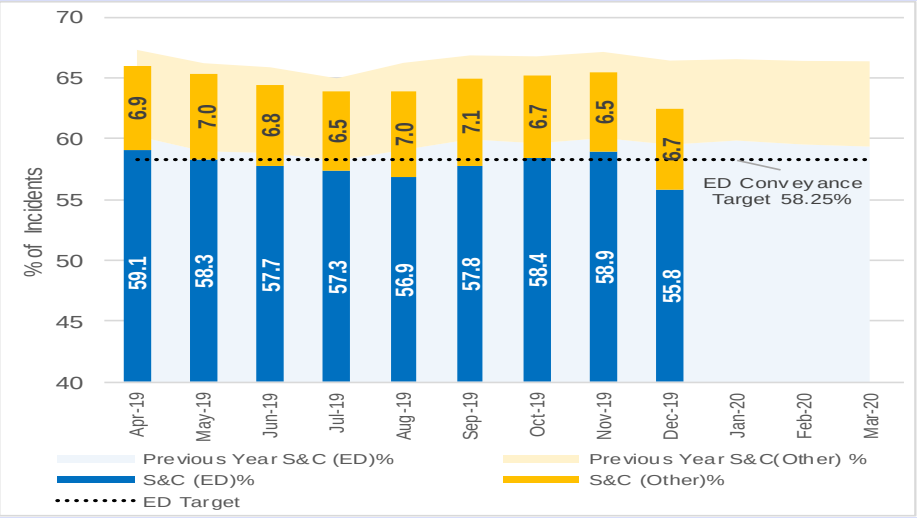
Max average breach value
Value >7 mins per breach

Maximising safe non-conveyance to ED

See and Convey to Emergency Department

		Dec-19	Year To Date	Year-end Target
See & Convey ED %	LAS	55.8%	57.8%	
	Target			

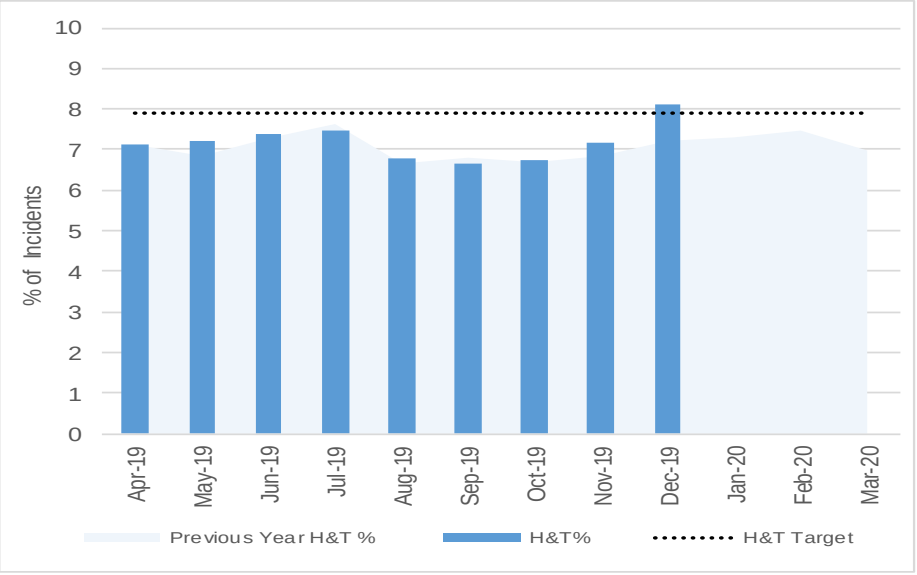
The conveyance to emergency departments target (58.25%) was strongly delivered in December (55.8%). The metric has been steadily improving over the recent months. The Programme Manager to support the emergency department conveyance programme is working closely with a number of directorates including Operations.



Hear and Treat %

		Dec-19	Year To Date	Year-end Target
Hear & Treat %	LAS	8.1%	7.2%	
	Target			

Hear and treat delivered 8.1% in May against the Trust target of 7.9%. These results are an improvement on 2018/19 rates and impending recruitment to the new CHUB structure is supporting an improved position.



Please note:

999 performance data is correct as at 08/01/20 and is subject to change due to data validation processes

Business Plan Deliverables

Ref	Business Plan Deliverable	SRO	Status	Comment
BP.17	We will improve the quality of care we deliver to patients through ongoing digital transformation to reduce our reliance on paper forms and to digitally connect and share information with other relevant health system partners.	Ross Fullerton		Adastra is now live in the Clinical Hub providing access to directory or services and detailed local care records. Summary care record pilot is complete. ePCR procurement is complete. The CAD replacement programme is underway.
BP.18	We will work closely with London acute hospital EDs, NHSI and NHSE to further reduce delays to patients and our crews at hospitals, especially during times of peak pressure on the wider system	Khadir Meer / Pauline Cranmer		The Director of Ambulance Services continues to meet with the regional hospital handovers lead for NHSE on a bi weekly basis to review activity of handovers at EDs, against the trajectory of eliminating 30min+ delays. National oversight of the regions most challenged sites continues on a monthly basis. Locally engagement is in place through the ADO teams. Despite this activity there is a rising trend in delays awaiting handover across a number of sites.
BP.19	We will begin delivering our new 'pioneer services' set out in our strategy, specifically focusing on mental health, falls and supporting staff to refer to alternative care pathways across the London health economy that improves outcomes for patients and reduces conveyances to ED.	Trisha Bain		The winter programme that aims to roll-out mental health response across London has started on 13th January . Regular debriefs are being held to ensure the programme is safe and delivers the intended benefits in relation to reduction in ED conveyance. In the meantime, work with Oxleas and SLAM continues with regular meetings and agreements to roll put the programme on a permanent basis.
BP.20	We will work with the London Health system to achieve our vision to become the primary integrator of emergency and urgent care (999, all 111/IUC providers), including bidding for 111 contracts as necessary and strengthening relationships with other health system partners.	Fenella Wrigley		LAS has continued to engage with Pan London strategic leaders and LAS lead commissioners to identify opportunities for better 999 and 111 service which will better meet the health needs of patients in London. Two aspects from the Perfect Day are being implemented as part of a London Winter initiative – 999/111 integration for Cat 5 patients to ensure the access to the most appropriate further assessment and onward care and the Joint Mental Health Car Response. The mobilisation of these is being done one STP at a time and both have commenced as of week beginning 13th January with early indications of good outcomes. Work continues through the joint LAS / STP 111/999 Board on future plans.
BP.21	We will deliver the key elements in our Quality Plan for 2019/20 to improve patients' experience and quality of care for patients.	Trisha Bain		Following the receipt of the CQC reports the quality governance team are now working with relevant directorates to produce comprehensive plans to ensure that the identified 'must dos' and should dos' are delivered and monitored, and that all actions are x-referenced and included in current business planning agreements. The plans will we monitored via QOG and to the Board via QAC. In addition a review of QSIR trained staff is under way to provide further training to operational teams to ensure staff are supported in delivering their sector QI plans.

Business Plan Deliverables

Ref	Business Plan Deliverable	SRO	Status	Comment
BP.22	We will respond to the CQC recommendations by continuing to improve the quality and security of our drug management through the roll-out of our Secure Drug Rooms, Primary Response / ALS bags, Vehicle-based multi-dose drug packs and enabling IT applications and the delivery of all other actions within the Towards Outstanding plans by April 2020.	Justin Wand		Secure Drug Rooms - Balance of Phase 1 (5) and Phase 2 (15) Interserve will be fulfilling the project management and delivery of the programme in year. ALS (Advanced Life Support) bags continue to be rolled-out and well received by staff. Primary Response bags will be delivered September with roll-out plan to follow. Multi-Dose Drug Packs roll-out start date is dependent upon Kit Prep2. Frequent meetings continue to take place to develop a solution.
BP.23	We will be fully compliant with Data Protection Legislation, ensuring the Trust understands the importance of data protection, and reviews new projects and policies against their impact on information governance.	Philippa Harding		Challenges with recruitment have resulted in reduced capacity to deliver. This is being addressed through the use of additional external resource and work is being undertaken to establish the viability of the introduction of a managed service to sit alongside information security.
BP.24	We will work closely with other emergency services and partners (e.g. the Greater London Authority family and London's boroughs), fulfilling our statutory obligations and strategic commitment to collaborate, innovate and maximise the efficiency of our combined public service provision.	Lorraine Bewes		We continue to work with both blue light colleagues and the wider GLA family. Examples of this are the development of the London Emergency Services Coordination Centre (LESCC) the purpose of which is to facilitate and coordinate multi agency activity. It also provides a real time pan London risk and mitigation function. A table top exercise was undertaken on 20th Nov 2019 to understand if the original high level outcomes are achievable (i.e. a reduction in unnecessary deployments for all services, quicker response to incidents through shared situational awareness and shared level of risk through demand, resource availability and collation/access to each services databases). A further discovery exercise is planned for Feb 2020. With regards to working with the GLA, several working groups have come together including ICT and HR to look at greater efficiency across their respective areas.

5. Strategic Themes

Delivering our 5 Year Strategy

Our vision is to be a world class ambulance service in a world class city. We want to be London's primary integrator of access to urgent and emergency care 'on scene', 'on phone' and 'on line'. Our strategic themes are:

- Theme 1: Comprehensive urgent and emergency care coordination, access, triage and treatment, with multichannel access for patients
- Theme 2: A world class urgent and emergency response with enhanced treatment at scene and for critically ill patients a faster conveyance to hospital
- Theme 3: Collaborating with NHS, emergency services and London system partners to provide more consistent, efficient and equitable services to Londoners

We are delivering our strategy through: Our strategic programmes, A framework of enabling strategies and improved stakeholder engagement. Progress is detailed on the following slides

Delivering our 5 Year Strategy – Strategic Programmes

N.B. for future IPR submissions, the following section will be changed to reflect the new portfolio of strategic programmes currently being agreed by Executive Committee and will be managed through the Strategy, Technology & Development and PMO functions

Programme	Key Progress & Achievements since last IPR	Priorities for coming months
iCAT London	999 to 111 / CAS referral pathway established for a cohort or category 5 patients including clinical governance sign off of LAS process across London with all 11 providers in London. Development of Category 5 and Clinical hub transformation project with Go – Live January 2020. New call flow process connecting 999 and IUC providers to better facilitate the transfer of care.	• Successful switch over to v13.2 AMPDS • Go-Live Category 5 Project – increase the number of incidents resolved without the need for a face to face response • Completion of technical aspects of electronic transfer of cases from 999 to each of the London IUCs • Alternative Care Pathway development specific to patients being managed through remote clinical assessment
Pioneer Services	Since October, we have been working to plan and mobilise an accelerated roll out of our Mental Health (MH) pioneer service across London with the aim of easing some of the pressures on emergency departments through the winter months. Whilst we were already planning for a pan-London roll out, we were asked by the NHS system in London to operate this model of care across London from January to March 2020. Whilst the pilot of this pioneer service paired an LAS Paramedic with an LAS MH Nurse, this expansion will see us dispatching our Paramedics alongside a MH Nurse from one of the ten MH Trusts in London. A significant amount of work has gone into designing the roll out both internally, and externally through working with the MH Trusts in order to put the appropriate governance structures in place and advertise for and select the clinicians to staff this service. The STPs and MH Trusts have been very supportive of this piece of work. We will be conducting a full evaluation to identify the benefits or challenges associated with this model and the larger scale roll out. In addition, we continue to work with South London and Maudsley and Oxleas MH Trusts to scope the continued roll out of this MH service beyond the end of winter.	• Continue to implement the winter roll out of the Mental Health pioneer service • Conduct a formal evaluation to identify the benefits or challenges associated with a larger scale roll out • Continue working with SLAM and Oxleas on the work to scope the roll out from April onwards which we hope will be funded through national 'Mental Health Ambulance' monies.

Delivering our 5 Year Strategy – Strategic Programmes

Programme	Key Progress & Achievements since last IPR	Priorities for coming months
Spatial Development	• **Second floor HQ refurbishment** is now complete and the medical staff now occupy this area. This includes another two meeting rooms for use by all staff. • Work to the **communal corridors** is now complete and includes breakout spaces being used by staff for informal meetings. • Work to the **HQ third floor toilets** will be completed by the 20th January 2020 to increase the provision of accessible toilets onsite. Accessible toilets will now be available on both the ground and top floors. • Works to **HQ first floor East** have started with a completion date of the 31st January 2020. **Pocock Street** works will be completed by the 13th January 2020 ready for occupation.	• 1st floor West and Cody road designs will be signed off and sent out for quotes shortly. • Cody Road roof works contract will be awarded in the next month. • Union Street decant will start in the coming weeks.
Digital 999	Relaunch of Connecting Clinicians as Digital 999 Programme: • ePCR supplier evaluation and Final Business Case complete and submitted for approval • Control room system OBC complete and submitted for approval • Programme, procurement and SME teams fully established Access to Summary Care Record rollout underway with CQUIN targets met for 2019/20.	• Contract award mobilise ePCR • Commence the tender process for the CAD
Ready, Set, Go (Medicines Management)	• **Secure Drug Rooms -** Moved to the spatial programme and will be reported as such. • **Multi Dose Pack -** Delivery to commence in 20/21. • **Advanced Life Support Bags** – Trust wide rollout complete 29/11.Withdrawal of personal issue paramedic bags commenced with the exception of FRUs as it has been agreed personal issue bags will be withdrawn as the primary response bag rolls out to each sector to ensure health and safety standards are met with appropriate handling of bags. • **Primary Response Bags -** Rollout commenced 25/11/19 - 40% of the Trust has gone live with the new primary response bags (NE & NC). Current issue is missing equipment particularly in North East. North \West scheduled to go live 08/01/2020. Oxygen barrel bags are being withdrawn from service as each sector goes live. • **Kit Prep** - User acceptance testing for Kit prep Depot app commenced November 19. Initial feedback is positive with minor issues to be resolved. Escalation to supplier to resolve. Challenges to complete due to staff availability to conduct UAT. BAU activities prioritised.	• Identify solution to issuers around make ready/24 hour vehicles • Complete withdrawal of personal issue paramedic bags • Complete Trust wide rollout of primary response bags • Complete end to end testing of Kit Prep 1- user acceptance testing of Depot App • Kit Prep 2 development and delivery • Commence Multi dose pack delivery

Delivering our 5 Year Strategy – Strategic Programmes

Programme	Key Progress & Achievements since last IPR	Priorities for coming months
Contracting and contractual form	• The main 999 contract was signed in November 2019. Commissioners will fund £373m, with an additional £2.5m to fund the EAC pay review. • Agreement has been reached for LAS and the LAS Commissioning Team, with STP Finance support to commence work on an integrated contract form for 2020/21 that covers the main emergency services contract, as well as integrated urgent care. This will support delivery of the Trust's strategic aim to deliver integrated care across London. • The Contracts team is now fully established with substantive members of staff and is recruiting an additional post to support costing.	• Liaison with NHSI to determine LAS commissioning arrangements for 2020/21 onwards • Preparation for 2020/21 Contract round including close working with Business Planning and Operations • Recruitment of Service Line Reporting & Costing Manager

Delivering our 5 Year Strategy – Effective Stakeholder Engagement

One of our three strategic themes, as outlined in our organisational strategy, is that we want to have a stronger working relationship with our key stakeholders across London, particularly NHSE, NHSI, the five STPs and London's CCGs. In order to achieve this we have restructured and expanded our stakeholder engagement function with the aim of being able to focus this engagement work on the key strategic issues.

Key strategic level forums attended

- SEL STP Board
- Regular Quarterly meeting between LAS Strategy and NEL STP
- Pan-London ACP and Demand Management Board
- STP A&E Delivery Boards (SEMs)
- SWL UEC Transformation Board
- SWL Board Seminar

Progress since the last IPR

- All the STPs have been focusing on developing and submitting their NHS Long Term Plan, and for some assessing their STP maturity and applications to NHSE/I. Therefore they have prioritised this over other activities and therefore many forums have been suspended e.g. SEL Provider Federation, NCL's Strategy Directors Forum etc.
- We worked closely and contributed to SEL's NHS Long Term plan submission in December.
- We worked closely and contributed to the SWL UEC Transformation Board and the SWL Board seminar
- We have continued to work with NEL STP to enable greater and better engagement in the absence of any formal forum at a strategic level.
- The SEMs continue to engage through forums such as the A&E Delivery Board and supporting winter planning in their sector.

Key priorities for the coming months

- Work with STPs as they develop their ICS plans and submission to NHSE, especially SW London; and as they undertake appointment of a single Chair as they form a single entity by way of a CCG/STP
- Strengthen partnership working, collaboration with NEL STP

Enabling Strategies

Strategy	Lead Director	Progress since last IPR	Key progress over coming months
Strategy	**Lead Director**	**Progress since last IPR**	**Key progress over coming months**
People & Culture Strategy	Ali Layne-Smith Director of People & Culture	The People & Culture Strategy has now been signed off by Trust Board	The Strategy and People & Culture teams are working to develop a detailed 3 year implementation plan which will inform the business plan which is now in development
Learning & Education Strategy	Ali Layne-Smith Director of People & Culture	The Learning & Education Strategy has now been signed off by Trust Board	The Strategy, People & Culture and Medical Directorate teams are working to develop a detailed 3 year implementation plan which will inform the business plan which is now in development
Digital Strategy	Ross Fullerton, Chief Information Officer	The Digital Strategy has now been signed off by Trust Board	The Strategy and IM&T teams are working to develop a detailed 3 year implementation plan which will inform the business plan which is now in development
Clinical Strategy	Fenella Wrigley, Chief Medical Officer	The Clinical Strategy has now been signed off by Trust Board	The Strategy and Medical Directorate teams are working to develop a detailed 3 year implementation plan which will inform the business plan which is now in development
Quality Strategy	Trisha Bain, Chief Quality Officer	The Quality Strategy has now been signed off by Trust Board	The Strategy and Quality and Assurance Directorate teams are working to develop a detailed 3 year implementation plan which will inform the business plan which is now in development
Estates Strategy	Khadir Meer, Chief Operating Officer	The Estates Strategy vision document has now been signed off by Trust Board	Delivery approach is being scoped and existing implementation plans (e.g. for work on corporate buildings) being incorporated into business plan where relevant
Volunteering Strategy	Antony Tiernan, Director of Communications & Engagement	The Volunteering Strategy vision document has now been signed off by Trust Board	The Strategy and Communications teams are working to develop a detailed 3 year implementation plan which will inform the business plan which is now in development
Public and Patient Engagement Strategy	Antony Tiernan, Director of Communications & Engagement	This strategy has now been fully scoped and is in development	This strategy will be taken to Trust Board in March for consideration
Commercial Strategy	Lorraine Bewes, Chief Finance Officer	This strategy has now been drafted	Each directorate will be engaged with on the draft commercial strategy before being considered by ExCo in February and then by Finance & Investment Committee and Trust Board in March

London Ambulance Service NHS Trust

Report to:	**Trust Board**			
Date of meeting:	28 January 2020			
Report title:	Health, Safety & Security Quarterly Report 2019/20 (Q2 and Q3 (up to end of November 2019)).			
Agenda item:	Additional report, circulated for information only			
Report Author(s):	Edmund Jacobs, Head of Health, Safety & Security			
Presented by:	Dr Trisha Bain Chief Quality Officer			
History:	N/A			
Status:	☒	**Assurance**	☒	**Discussion**
	☐	**Decision**	☐	**Information**

Background / Purpose:

The purpose of this report is to highlight key items of discussion from the Corporate Health and Safety Committee meeting held on 24 October 2019, as well as to provide an update on the Quarterly Health & Safety Review Report, in order to provide assurance/highlight any issues that might impact the successful implementation of the recommended actions.

The report is supported by the following documents:

- Section 3: Policy and Legal Compliance
- Section 4: Projects and Programmes
- Appendix 1: Summaries of Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)

The Health and Safety Scorecard is attached to the report for reference – providing an overview of the Trust's health and safety performance from 2019/20 (Q2 and Q3 - up to end of November 2019).

Recommendation(s):

The Board is recommended to comment on the attached information.

Links to Board Assurance Framework (BAF) and key risks:

N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☒
Financial	☐
Workforce	☐
Governance and Well-led	☒

Reputation	☒
Other	☐
This report supports the achievement of the following Business Plan Work streams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☐

Executive Summary

Highlights:

1. The Trust's Health and Safety mandatory training compliance rate in November 2019 has increased to 92.46% exceeding the Trust-wide target of 91%.

2. The First Aid training programme commenced in December 2019, which is delivered in collaboration with the First Responder Department to staff from all areas of the Trust. The target is to deliver a further three courses to ensure that we are compliant with the First Aid Regulations.

3. The Health, Safety and Security Department has set up a rolling programme of Fire Marshall training. To ensure appropriate cover across main sites, we currently have 154 Marshalls throughout the Trust and the target is to have 180 Marshalls by end of Q2 (2020/21).

4. There is a rolling programme to deliver the updated and certificated Managing Safely course. To date, 96 Managers (including Senior Managers) have received this training during Q2 & Q3 (up to end of Nov'19). It is planned to train a further 165 Managers (including Senior Managers) by end of Q4 2020/21. The Health, Safety & Security Department have also updated the 'Manager Responsibility' section on the Managing Safely course to raise awareness concerning the P&C process for dealing with Occupational Health reasonable adjustments. The Trust Board Health & Safety briefing will be delivered during February 2020.

5. As one of a number of ways it seeks to reduce assaults on staff, the Trust has agreed for a centrally funded trial of Body Worn Video Camera to address violence and aggression to be carried out this financial year. This will be a project led programme and is now being developed within the Trust wide QSIR programme.

6. The Health, Safety & Security Department have introduced a new process in relation to violence and aggression. Following the reporting of any moderate harm or above related violence and aggression incident, Datix will trigger a notification to the Chief Executive and Chief Operating Officer, who will contact the victim by letter and/or phone call. We are seeking closer cooperation with police following up assault incidents through 'Blue Light Collaboration' work and the Metropolitan Police's Operation Hampshire dealing with prosecutions under the Assaults on Emergency Workers (Offences) Act 2018, (see section 2 - Projects and Programmes). In addition to the conflict resolution training with GRS, we are also reviewing the Trust's approach to restraint and the feasibility of providing training. To deliver this project, a Task & Finish Group has been set up to review current arrangements for operational restraint.

7. As part of the CQC Inspection Report feedback, the Health, Safety & Security Department has increased the frequency of the Security 'mystery shopper' visits to take place in January, February and March (Q3) 2019/20. Thereafter, a review of standards of security of vehicles and at ambulance stations will take place in collaboration with operational leads. This Security audit trail will be embedded into the Health Assure system, with feedback to Sectors, and to track compliance.

8. The Task and Finish Group was set up to take forward the need to review and develop generic operational risk assessment and underpin dynamic risk assessment arrangements across the Trust. All areas of operations have been identified (for risk purposes) and points of operational lead identified. A rolling programme to deliver generic operational risk assessments will commence in January 2020, aligned to the

application of dynamic risk assessment will be drafted by end of Q2 (2020/21), and will be subject to a review thereafter.

9. Health, Safety & Security Department have developed an MSK Action Plan, which will be a project led programme and presented to Manual Handling Steering Group and to the Corporate Health, Safety and Security Committee. This covers all areas of the Trust, this is due to be converted into a QSIR project plan. This includes:

   (i) 'Back Care awareness' poster campaign, and the request to Communications Department to have a message displayed in stations via TV screen.
   (ii) New categories/sub categories have been agreed for moving and handling related incidents by the Datix User Group and introduced during Q3 (2019).
   (iii) Representatives from the Trust attending a Symposium run by the Association of Ambulance Chief Executives in collaboration with Manchester University to cover Prevention, Control to Reduce Risks and Supporting Staff in relation to Moving and Handling, in December 2019.

10. Health, Safety & Security Department have developed and presented statutory related policies: Asbestos Management, Water Systems, Control of Contractors, and Permit to Work Management to Estates Department for implementation, through the consultation and the approval process.

Lowlights:

11. Trust wide compliance for the completion (bi-annual) of Fire Drills is currently at 85%. The compliance for completion of quarterly H&S site inspections for Q2 (2019/20) was 85% and in Q3 (up to end of November 2019) is at 65%. It is envisaged that this will rise by the end of Q3. A process is in place that escalates areas of non-compliance to the LGM's to monitor the position.

12. 14 out of the 56 RIDDOR incidents reported during Q2 (2019/20) and 3 out of the 30 RIDDOR incidents reported during Q3 (up to end of Nov'19) were outside the 15 days' timeframe. This continues to be an area of focus and is reported at LGM/QGAM meetings.

13. Trust wide compliance for the completion of the statutory required annual site specific Risk Assessments is currently at 70%. The Health, Safety and Security Department have in addition to escalating this position to LGM's/QGAM's, the Health & Safety Advisors are providing assistance to the LGM's.

14. The Health, Safety & Security Department have updated the draft Trust Stress Policy and have also updated the risk assessment template. This has been provided to the Task and Finish Group for appropriate action, awaiting approval from People and Culture Directorate for promulgation.

POLICY & LEGAL COMPLIANCE

15. The quarterly (Q2, 2019/20) also includes Q3, (up to end of November 2019)) Health, Safety and Security performance review has been conducted. The updates and developments made to improve the service are provided below.

Maintenance of legislation register:

16. Programme of updating Fire Risk Assessments (FRA) Trust wide have been completed successfully and the compliance is 100%. FRA action tracker has been developed and

the identified themes have been circulated to relevant management for action. FRA working group has been formed to review actions on regular basis. The annual statutory compliance (including fleet maintenance) assurance report is provided to the Corporate Health & Safety Committee.

Policies and management systems aligned to operational requirement:

17. The Health, Safety & Security Department have developed and presented statutory related policies: Asbestos Management, Water Systems, Control of Contractors, and PTW Management to Estates Department for implementation, through the consultation and the approval. The updated Trust First Aid Policy is available on the Pulse.

18. The Health, Safety & Security Department are developing a Quality Directorate health and safety handbook, with a view that this senior management approach to leading on health and safety leadership is rolled out across other Directorates.

Good Governance:

19. Health, Safety & Security Department are producing monthly Safety Performance reports for all the Operational sectors and the Quality report for the Directorates'. This highlights the identified issues and themes, in order to implement appropriate control measures and to improve staff, patient and others safety, and to identify and support appropriate future learnings to promote awareness.

20. The Staff Safety & Security Group is in place and meeting six weekly. The identified issues are escalated to Corporate Health and Safety Committee to raise awareness to Senior Management and to take appropriate action.

21. There is a programme to run Security Mystery Shopper visits, and this will recommence in January 2020, through to February and March, and will be subject to a quarterly review.

22. Health, Safety & Security Department have updated the Manager Responsibility section on the Managing Safely course to raise awareness around the process for dealing with Occupational Health adjustments.

23. The Staff Safety & Security Group is in place meeting six weekly. The identified issues are escalated to Corporate H&S Committee to raise awareness to Senior Management and to action accordingly.

24. A Health & Safety Committee have been developed in NE and NC sectors has now been established. The identified issues are escalated to Corporate H&S Committee to raise awareness of Senior Management and to action accordingly.

Risk Management: Assess, control and minimising health and safety risks:

25. A Task and Finish Group is in place to take forward the need to review and develop operational and dynamic risk assessment arrangements across the Trust. This will enable support and improve the quality of the service the Trust provides to promote and foster safe systems of working.

26. The Health, Safety & Security Department is to produce visual aids for moving and handling activities, with the assistance of front line crews which will compliment risk assessments and Standard Operating Procedures. An e-learning Moving & Handling

package is being delivered as part of CSR 2:2019. Load handling training has also been delivered to other Departments/Teams where moving and handling tasks are a main part of their role, such as Fleet and Logistics.

27. The Health, Safety & Security Department are producing the Trust-wide monthly Violence & Aggression report to highlight the identified issues and themes to implement appropriate control measures and to improve staff, patient and others safety. Also to identify/support appropriate future learnings to promote awareness. It is proposed that a category to identify attendance at hospital by staff victim of assault to be added to Datix which will enable the monitoring process to identify and to provide necessary assistance to staff member.The Health, Safety & Security Department are producing the monthly update on Body Worn Video Camera (BWVC) project as part of the Trust-wide Performance Safety report.

28. The Health, Safety & Security Department have updated Stress Policy and have also updated the risk assessment template which has been provided to the task and finish group for appropriate action.

Ensuring all staff are aware of their health and safety responsibilities and receive relevant training that appropriate to the role they perform:

29. The Health, Safety & Security Department have updated the Manager Responsibility section on the Managing Safely course to raise awareness around the process for dealing with Occupational Health adjustments. We have delivered 7 sessions of the updated course to 96 Managers / Senior Managers during Q2 & Q3 (up to end of November 2019).

30. First aid Training is being delivered in collaboration with the First Responder Department to staff from all areas of the Trust to ensure that we are compliant with the First Aid Regulations.

31. Fire Marshall training is underway, we currently have 154 Marshalls throughout the Trust but this training will continue throughout this financial year.

32. The Health, Safety & Security Department are developing new procedures to mitigate against non-attendance for Health, Safety & Security related training courses.

Delivery of key Health and Safety training and implementing arrangements for monitoring the effectiveness of training provided to staff and competency:

33. All the training delivered by Health, Safety & Security Department includes certificate of attendance and an evaluation form as part of continual improvement. A draft Health & Safety Training Policy is being developed, which will be out for consultation by end of Q4 2019/20.

34. Health, Safety & Security Department are currently developing a Display Screen Equipment Assessor training package which will be launched in Q4' 2019/20, this will ensure that staff have access to a trained assessor within their work area who will act as their main point of contact for DSE.

35. Health, Safety & Security Department are updating the Incident Investigation module for the Managing Safety Course, and have incorporated a COSHH module to the course.

This course now also includes a delegate handbook and action plan section to assist Managers in applying tools and techniques back in the workplace.

36. Health, Safety & Security Department are developing a New & Expectant Mothers Risk Assessment Training Module for ICU.

37. Health, Safety & Security Department are working with the Fleet & Logistics Teams to improve the failure rate of Mangar Elks, through RCA of incidents, bulletins are to be produced for both frontline staff and Make Ready Teams to help reduce the current incident level.

Promoting, encouraging participation and supporting initiatives that enhance OH and wellbeing for staff:

38. A back-care health promotional poster campaign has been developed to raise awareness around reducing musculoskeletal related injuries, which has been rolled out across the Trust. Work with Communications & Wellbeing Department is in place to have a message displayed in stations via TV screen.

Adopting a preventative approach to reducing sickness absence and proactively managing cases of ill health in order to keep staff at work/ facilitate a timelier return to work:

39. With the integration of ESR/GRS to improve the collection and understanding of ill-health and sickness absence data along with the introduction of investigation training for managers and the support by the wellbeing team.

40. Stress Management Planning Workshop with P&C Team are scheduled to take place on 20th January 2020 to agree how the Trust roles out the Level 1, 2 and 3 stress Training.

PROJECTS & PROGRAMMES

Body Worn Video Cameras (BWVC)

41. Body worn video Cameras (BWVC) Standard Operating Procedure being developed prior to the start of the BWVC trial for agreement by Corporate H&S Committee. New Workplace Violence Policy being developed. The existing Violence Avoidance and Reduction Procedure and the Post Violence Support Procedure will then become appendices of the new policy. The Policy to be agreed by Corporate Health & Safety Committee.

42. NHS England / Improvement has indicated a funding settlement of circa £175,000 for the LAS to trial Body Worn Video Cameras (BWVC) as part of phase 1 of the National trial of BWVC to commence this financial year (2019/2020).

43. Body Worn Video Cameras (BWVC): small cameras worn on the body by frontline staff, to record visual (and often audio) interaction between public and wearer. Saved footage is encrypted securely on the device can be downloaded and may then be used as evidence in criminal prosecutions. BWVC are primarily seen as a form of ‘personal protective equipment’. These devices are believed to help reduce the impact of violence against staff. The trial is intended to evaluate their effectiveness in doing so.

44. Funding is being made available centrally for the trial to take place, although it is yet to be released and the final funding amount for each Trust is to be confirmed. However, as part of the first phase, NHS England / Improvement has indicated a funding settlement of circa £175,000 for the London Ambulance Service NHS Trust (LAS) to trial BWVC for 12 months, the first phase commencing this financial year (2019/20). This funding should cover the costs of procuring cameras, docking stations, cloud storage and electronic issuing system. Part of the funding may be used to contribute to the cost of dedicated project support, including IT support.

45. All Trusts in the first phase will be required to use a commercial framework agreement to procure BWVC units. One such current framework available to use is from the East Midlands Strategic Commercial Unit, which incorporates nine suppliers, who all meet prescribed standardisation for the equipment/technology.

46. The London Ambulance Service would be expected to bear the costs of funding BWVC for subsequent years following the first year, if the trial is successful and the LAS agree to take forward the provision of BWVC for staff. These costs would include any further Body Worm Video units required and all ongoing storage.

47. A successful trial of body worn cameras at the LAS will evidence a reduction in the levels of violence and aggression experienced by staff, enabling the risk (678) to be reduced from 9; significant, to its target rating of 6; moderate. The potential benefits of a reduction in violence and aggression include:

    - Improved staff morale due to investment of cameras to protect their Health and Safety;
    - Improved and seamless evidence gathering in circumstances where Police involvement is required;
    - A decrease in the time taken to provide sufficient evidence to support a prosecution;
    - An increase in the number of successful prosecutions;
    - Improved Staff Survey results;
    - Improved Staff engagement, motivation and security as a direct result from investing in staff health, safety and wellbeing;
    - Increased Patient Care, patient experience and patient engagement;
    - Reduction in the risk of violence and aggression towards staff from an improved level of care provided to staff under Health and Safety duty of care;
    - Reduction in staff sickness levels resulting from violence and aggression incidents;
    - Reduced pressure on resources from fewer crews being taken off the road following violence and aggression incidents.
    - Enhanced relationships with stakeholders, including staff-side;
    - Mitigation to reputational damage related to assaults experienced by LAS staff.

48. North East Ambulance Service (NEAS) undertook a small scale pilot funded by a provider October 2018 – January 2019. They are now part of the first phase of the centrally funded 12 month National Trial with North West Ambulance Service (NWAS) and LAS. NEAS have provided feedback on their trial which is being used to inform the LAS trial. The LAS is liaising closely with both NEAS and NWAS. Additionally, the LAS is also liaising with the Metropolitan Police, who are one of the largest users of Body Worn Video Cameras in the world, around the management of BWVC.

49. NHS England/Improvement have forwarded the Memorandum of Understanding relating to the provision of funding for the trial and this is currently being reviewed by LAS procurement.

Violence and Aggression

50. The Health, Safety & Security Department have introduced a new procedure to monitor Police involvement in incidents of violence and abuse of LAS staff to help capture prosecutions and log outcomes also to promote awareness across the Trust. Following the reporting of any moderate harm or above related violence and aggression incident, Datix will trigger a notification to the Chief Executive and Chief Operating Officer, who will contact the victim by letter and/or phone call.

Violence and Aggression report background:

51. Work to address the issue of workplace violence and aggression affecting the NHS, including Ambulance Trusts, was previously directed and supported centrally by NHS Protect (originally called the Counter Fraud and Security Management Service). NHS Protect effectively ceased operations relating to security management (including workplace violence) on 31st March 2017. This removed the support provided to NHS organisations from NHS Protect's Legal Protection Unit (LPU). The LPU provided guidance and advice on criminal justice. NHS organisations must now seek guidance independently. The Datix Risk 678 records the risk of physical and non-physical assault to frontline staff who come into direct contact with patients and members of the public during the course of their work. The risk is currently rated at 9; significant.

Violence and Aggression report Issues:

52. LAS crews are being assaulted while doing their jobs. The LAS experiences the highest number of physical assaults reported nationally across ambulance services. Last year (2018/19) the LAS had 468 reported incidents of physical assault. From April 2019 up to the end of November 2019, there were 456 Datix reports submitted relating to physical assault. These assaults range in severity from incidents resulting in no harm, through to incidents resulting in moderate harm. Police attended 275 of the 456 incidents. For the same period we have recorded 4 successful prosecutions. More prosecutions may have been successful but to date these outcomes have not been fed back.

53. Often police investigations following an assault can be prolonged. This may result in crime reference numbers not being communicated to local management teams and/or the Health, Safety & Security Department and a lack of any progress or outcome of investigation advised. As a result of the extended period of time, staff may believe there is a lack of traction and lead them to feel unsupported by the organisation and/or the police.

54. It is recognised that following up assaults and calling police for updates on prosecutions is placing a burden on CTMs and LGMs and that the level of support given to victims at a local level is not consistent.

55. The level of activity in managing the issue of violence against LAS crews requires a dedicated resource. This would enable incidents to be consistently and effectively followed up with victims, providing appropriate advice in criminal justice and support through the criminal justice system and then to follow up investigations with the police and track and monitor the outcomes.

Violence and Aggression report Actions:

56. In order to capture assault investigation outcomes, the Health, Safety and Security Department have recently implemented a system to track and monitor reported incidents where staff have been assaulted and the police have arrested the assailant as well as incidents where, either it is deemed that the police should have arrested the assailant from what was written in the Datix report, or where police should have been requested because of the assault but were not called.

57. To further improve communication between the LAS and the Metropolitan Police Service (MPS), a meeting has been arranged on 7th January for the MPS Lead for Operation Hampshire to present this approach to the LAS which involves supporting staff who are victims of assault and in pursuing justice in dealing with assaults on Emergency Workers.

58. A memorandum of understanding between the LAS and MPS is being drawn up for agreement at the highest level within both organisations. This would provide an agreed joint approach in dealing with assaults on LAS staff and would further evidence that the LAS does not and will not tolerate assaults against its staff.

59. NHS England/Improvement are currently working on a project to gather data on staff assaults nationally and which is planned to go live from the 1st April 2020. The LAS is currently contributing to this project.

60. NHS England/Improvement further plan to introduce Violence Reduction Standards. As part of the NHS Standard Contract, Service Condition 24. NHS Providers and NHS Commissioning organisations will be required to be fully aligned with or working towards achieving compliance with the indicators within the Violence Reduction Standards. . These have been developed using the plan, do, check, act (PDCA) approach. PDCA is an iterative four-step management method used to validate, control and achieve continuous improvement of processes.

61. Closer cooperation with police being sought in following up assault incidents through Blue Light Collaboration work and the Metropolitan Police's Operation Hampshire dealing with prosecutions under the Assaults on Emergency Workers (Offences) Act 2018. It is proposed that any Datix incident that is subject to an external investigation, such as a police criminal investigation, should remain open until the result of that investigation is known (eg, a successful prosecution with sentence details). Meeting with the New Met Police Counter Terrorism Security Advisor arranged for January 2020 to discuss presentation to ExCo. A meeting between LAS and Met Police (MPS) arranged for early January 2020 to discuss MPS Operation Hampshire, which is related to work the MPS have undertaken to support staff and in pursuing prosecutions in line with the Assaults on Emergency Workers (Offences) Act 2018 following assaults.

62. The Health, Safety & Security Department have developed a Musculoskeletal (MSK) action plan and will form part of the wider Health & Safety Strategy. A programme Board similar to that of the violence reduction board is being developed using the same principles and staff who have been trained in QI methodology. Both programmes will start in February 2020 and reporting and monitoring through current programme governance arrangements and the Health and Safety Committee. Due to the collaboration required between Occupational Health and the Health and safety department it is proposed that the Health and Safety Committee is renamed the Health,

Safety and well Being Committee jointly chaired by CQO and Dep Director of People and Culture.

Musculoskeletal Action Plan

63. The MSK Action Plan is an integral part of the Trust's Strategic Health and Safety Plan and is aligned to the Quality and Assurance 3-year Business Planning - Directorate Priorities.

Objective 1- Continually improve moving and handling systems and processes to reduce the risk and impact of MSK issues and injury in the workplace.						
Ref	**Goals and action Steps**	**Due date**	**Person/s Responsible**	**Evaluation Plan**	**Progress Update**	**Co-dependencies, exception reports and barriers**
1.1	Co-create physical and audio-visual aids for staff on the safe use of equipment.	Mar 2020	• Kerry Fowler • Clinical Education and LEaP Teams	• Evaluate feedback. • Monitor events and incidents involving equipment to identify impact and trends. • Use data and feedback to continually improve the offering.	• First meeting undertaken, with all SOP's identified.	
1.2	Create a link on the IPad and via the PULSE to the resources.	June 2020	• Internal Communications	• Measure and report the frequency with which staff access the resources.		
1.3	Embed the HSE MAC assessment approach into CSR	Mar 2020	• Kerry Fowler • Terry Light			
1.4	Review and integrate moving and handling principles and practices including use of equipment in scenario based training opportunities.	Apr 2020	• Kerry Fowler • Terry Light	• Monitored on a quarterly basis.		
1.5	Co-create and Disseminate Core Moving and Handling Equipment Risk Assessments	Mar 2020	• Kerry Fowler • Health and Safety Representatives • Internal Communications	• Measure the degree of dissemination and end user understanding of the core risk assessments. • Monitor events and incidents involving equipment to identify impact and trends.	• First meeting undertaken, with all SOP's identified.	

				• Use data and feedback to continually improve the offering.		
1.6	Review, redesign and implement changes to OWR once the new core risk assessments, tools and training have been agreed.	Jun 2020	• Kerry Fowler			
1.7	Undertake a staff survey to understand the relationship between the reporting of Stress and MSK absence	Jan 2020	• Kerry Fowler • Edmund Jacobs • CARU	• Using the data to determine accuracy of reporting for MSK and Stress.		
1.8	Ensure that the Manual Handling Steering Group has Senior Management Engagement from all areas of the Trust and is used as the main driver of this Action Plan	Apr 2020	• Edmund Jacobs • Trisha Bain • Kerry Fowler	• Manual Handling Steering Group Report to feed into the Corporate Health & Safety Committee for oversight and escalation.		Currently no senior management chair and ToR and membership requires updating.

Objective 2- Improve the quality and consistency of MSK equipment issues, injuries and near miss reporting.						
Ref	**Goals and Action Steps**	**Due date**	**Person/s responsible**	**Evaluation Plan**	**Progress**	**Co-dependencies, exception reports and barriers**
2.1 2.2 2.3 2.5	Design and deliver incident investigation training, including a RCA approach to MSK injuries. Ensure the training emphasises the importance of: Giving a Datix reference on the defect form. Recording the equipment serial number in Datix. Ensuring that as part of the investigation that the defect report is reviewed to inform the root cause analysis and added to the Datix log.	Apr 2020	• Health, Safety and Security Department	• Ensure investigations include the impact of the equipment failure, or other causal factors if no defect is identified.	• Incident investigation prompts have been developed for all types of Health & Safety incidents including moving and handling. • Incident investigation training is embedded within the Managing safety course which is delivered monthly.	
2.6	Educate and empower workshops / estates and other partners on the importance of challenge when defect notifications are incomplete e.g. no Datix reference/asset number recorded.	Jun 2020	• Justin Wand • Steve Perks	• Create a system to monitor the quality of defect notifications. • Create a system to monitor and report trends in equipment failure.		• Co-dependencies with the Asset Tracking Project.

2.7	Educate and empower workshops / estates and other partners on the importance of ensuring they provide a report to the complex when they have assessed or repaired manual handling equipment failures as well as no failure detected reports.	Jun 2020	• Justin Wand • Steve Perks • Stephen Finch	• Create measures to evaluate the quality of incident reports and investigations.		
2.8	Implement new MSK coding options in Datix.	Oct 2019	• Kerry Fowler • Stuart Fitch	• Incident data collection from November onwards. • Daily/Weekly quality check of reported incidents to ensure a consistent approach to reporting.	• Completed coding on Datix. • Ongoing quality checking and monthly reporting	
2.9	Promote the new online-incident reporting programme.	Apr 2020	• Raja Habib • Stuart Fitch	• Evaluate uptake and impact.		
2.10	Monitor, analyse and report hot spots, trends and issues.	Jan 2020	• Kerry Fowler • Amarnath Nachimuthu	• Monthly review • Co-create targeted actions to address identified issues.	• Ongoing review. • Mangar Elk group has been set up with actions due to current failure levels seen in the incident reporting.	

Objective 3- Improve the resilience of staff who undertake moving and handling activities.						
Ref	**Goals and action Steps**	**Due date**	**Person/s responsible**	**Evaluation Plan**	**Progress**	**Co-dependencies, exceptions reports and barriers**
3.1 3.2	• Design and cost a day one of sickness absence referral to physiotherapy assessment pathway. • Launch day one referrals once costs are approved- may need to be small scale proof of concept in area with highest MSK absence initially.	Jun 2020 Jun 2020	• Roujin Ghamsari	• Evaluate the cost vs benefit to individuals and the Trust. • Monitor the MSK sickness issues and injury trends between November 2019 and April 2020. • Identify causal factors, work and non-work related.		• There may be a financial barrier as the change in practice may increase the cost of physiotherapy services. • Enabler for delivery of: ○ The Operational Delivery Plan ○ The Winter Plan ○ The NHSI Wellbeing Improvement Plan
3.3	• Create and distribute an MSK sickness absence assessment tool for Managers.	Jun 2020	• Gill Heuchan • Roujin Ghamsari • Internal Communications	• The quantitative impact the hypothesis is that there will be a reduction in average FTE's lost to MSK sickness and reduction in the cost due to unproductive time. • Qualitative evaluate the usefulness to managers and experience of staff. • The frequency the tool is accessed.		

3.4	• Create and launch a well in winter resource, including MSK injury prevention for staff. Make this available on the PULSE and via a link on the IPad.	Dec 2019	• Gill Heuchan	• Qualitative evaluation of the usefulness to staff and managers. • The frequency the tool is accessed.		• Enabler for delivery of: ○ The Operational Delivery Plan ○ The Winter Plan ○ The NHSI Wellbeing Improvement Plan.
3.5 3.6	• Design and cost pre and in employment fitness to work standards, assessments and personal fitness planning. • Including return to work following any long absence and specifically MSK absences and maternity leave.	Jun 2020 Jun 2020	• Nicola Bullen • DTUS • National Safety and Risk Forum (strand of work to formulate national standards for MSK issues) • Terry Light • Kerry Fowler	• Quantitative impact the hypothesis is that there will be a reduction in average FTE's lost to MSK sickness and reduction in the cost due to unproductive time. Evaluate the human and financial costs vs benefits. • Qualitative evaluate the experience of staff. • Improvement in engagement, MSK and employer cares about my wellbeing staff survey responses.		• Requires buy in from staff side to ensure this is delivered as a staff benefit not a punitive approach. • Enabler for delivery of: ○ The Operational Delivery Plan ○ The NHSI Wellbeing Improvement Plan ○ Operational Health Improvement Plan (Public Health)

64. The Health, Safety & Security Department are collaborative working with Quality Intelligence team to integrate H&S Audit Programme via My Health Assure.

INCIDENT INVESTIGATIONS:

65. During Q2' 2019/20, total of 56 RIDDOR incidents were reported & investigated and in Q3' 2019/20 (up to end of Nov'2019) total of 30 RIDDOR incidents were reported & investigated. The monthly break down of RIDDOR incidents were as follows: July (26), Aug (17), Sept (13), Oct (17), and Nov (13). The learning from the incidents investigation, thematic review of incidents, and actions taken are discussed below.

Learning:

66. The Sector wide achieves learning from incidents in a number of ways including:

- Automated emails are sent to the reporter on the incident on the completion of the investigation and any subsequent learning that has been identified.
- Face to face discussion, personal reflection and feedback to teams.
- Health, Safety & Security Department support shared learning alongside sector H&S Committee meetings.
- Sector Quality Meetings which includes incident themes collated from the monthly H&S incident analysis.
- Themes from incidents are provided via the monthly Sector and Trust Quality Reports to Trust Board and Quality Oversight Group (QOG).

Thematic Reviews:

67. A total of 56 RIDDOR incidents were reported in Q2' 2019/20. Top 2 incidents accounting for 79% of all RIDDORs are Manual Handling (59%) and Slips, Trips & Falls (20%). A total of 30 RIDDOR incidents were reported in Q3 2019/20 (End of Nov'19). Top 2 incidents accounting for Manual Handling (70%) and Slips, Trips & Falls (20%).

Key emerging themes:

68. Patient demographics:

- Difficulties in extricating "weight" challenging patients.
- Patients with mental, alcohol, dementia, patient behavioural and drug related issues.

69. Environmental factors:

- Confined spaces which make moving and handling difficult of patients.
- Challenging environments / terrains.
- Absence of light / wet surface.

70. Plant/ Logistic issues:

- Vehicle concerns and "poor planned maintenance".

71. Equipment Failings:

- Failure due to “poor planned maintenance”.

72. Availability.

73. Location/ fitting of these for use.

Personnel / Behaviours & “poor/ non appliance of training/ good practices”

74. Environmental challenges requires awareness and need to apply Dynamic Risk Assessment techniques.

75. Application of learning and techniques for safe outcomes (staff as well patients).

76. Lack of Proactive approach to reporting – faulty equipment, leaks, hazards.

77. General Health and well-being of staff.

78. Previous injury recurrence.

79. Failure to ask for assistance.

Others

80. The above when combined have also been contributory factors in the RIDDORs reported and so it is important staff make use of all the “tools” in their tool box –Personal Health and Well-being/ Ensure any / all equipment to be used is in “good working order”/ report any faulty equipment and awareness of the clients/ environments and equipment being used and exposed to.

Actions Taken & Recommendations:

81. From the report, we have taken the following actions, these relate to specific feedback systems and processes changes have been highlighted.

1.81.1 Staff members have been referred to physio.
1.81.2 Staff members to undertake appropriate refresher training on manual handling techniques.
1.81.3 Staff members have been advised to take care/more attention when entering and exiting the ambulance and use the handrails provided to give extra stability.
1.81.4 Staff members have been advised to use Dynamic Risk Assessment (DRA) techniques during frontline duties.
1.81.5 The staff member have been advised to request the extra crews when dealing with bariatric patient.
1.81.6 Staff members have been advised to request the second vehicle when they have an issue with equipment such as Manger elk failure.
1.81.7 The staff member has been advised to use his/her conflict resolution skills to try and diffuse the aggression of the patient.
1.81.8 Staff members have been advised to do a visual check before stepping down/out from the ambulance to make sure that, the ground level is not uneven.

1.81.9 The staff member have been advised about the importance and the requirements of using Personal protective equipment (PPE) when and where necessary.
1.81.10 The local management to review Risk assessment/process when and where necessary.
1.81.11 Important to remind all staff to keep to date with training in Manual Handling (Level and competence commensurate with task/ role).
1.81.12 Drive to ensure all staff have or will undertake training in Dynamic Risk Assessment. Monitor and ensure staff identified by grade /task and roles have completed training. The use of this tool and awareness would have a positive impact.
1.81.13 Importance of personal health and well-being must be emphasised by local management (LGM/CTM).
1.81.14 Staff members have been advised to report faulty/failure of equipment's through right channels and take them out of the service with immediate effect.
1.81.15 Summaries of RIDDOR incidents investigated 2019/20 (Q2 & Q3 (up to end of ember 2019)) see appendix 1.

Health & Safety Performance Reporting:

82. Trust Wide Health and Safety incident data were reviewed, a total of 1046 incidents were reported in Q2' 2019/20. 623 of the 1046 incidents were reported as Near Miss/No Injury. 423 incidents resulted in harm with 371 reported as 'Low Harm', 52 incidents were reported as 'Moderate Harm'.

83. Trust Wide Health and Safety incident data were reviewed, a total of 717 incidents were reported in Q3' 2019/20 (up to end of Nov'19). 391 of the 717 incidents were reported as Near Miss/No Injury. 326 incidents resulted in harm with 282 reported as 'Low Harm', 44 incidents were reported as 'Moderate Harm'.

84. Top 5 incident subcategories are: Physical assault by blow (Kick, punch, head-butt, push, scratch); Directed verbal abuse; Manual Handing; Slips, trips and falls; Premises.

85. Total of 56 incidents have been reported as RIDDOR in Q2' 2019/20

86. 33 (59%) of the 56 RIDDOR incidents reported in Q2' 2019/20 were related to manual handling incidents.

87. 11(20%) of the 56 RIDDOR incidents reported in Q2' 2019/20 were related to Slips/Trips/Falls incidents.

88. Total of 30 incidents reported as RIDDORS in Q3 2019/20 (up to end of Nov'19)

89. 21 (70%) of the 30 RIDDOR incidents reported in Q3 (up to end of Nov'19) were related to Manual Handling incidents.

90. 6 (20%) of the 30 RIDDOR incidents reported in Q3 (up to end of Nov'19) were related to Slips/Trips/Falls.

91. The timeframe compliance of reporting RIDDOR incidents (<15 days) to the HSE across the Trust during Q2' 2019/20 was 76% and in Q3 (up to end of Nov'19) is 90%.

92. An overview of the CAS/MHRA Alerts report – in 2019/20 (YTD) all of 368 alerts received have been assessed and processed appropriately.

93. Total of 512 security incidents have been reported in Q2' 2019/20.

94. Total of 289 security incidents have been reported in Q3' 2019/20 (up to end of Nov'19).

95. Total of 121 manual handling related incidents reported in Q2' 2019/20.

96. Total of 113 manual handling related incidents reported in Q3' 2019/20 (up to end of Nov'19).

97. The Trust-wide Fire Risk Assessment compliance is 100%.

98. Trust wide compliance for the completion of Fire Drills is currently 85%.

99. Health, Safety and Security Scorecard is attached for reference – providing an overview of the Trust's health and safety performance from 2019/20 (Q2 and Q3 (up to end of November 2019)).

Edmund Jacobs,
Head of Health, Safety & Security

London Ambulance Service NHS Trust

Report to:	**Trust Board**			
Date of meeting:	28 January 2020			
Report title:	Freedom to Speak Up Quarterly Report			
Agenda item:	Additional report, circulated for information only			
Report Author(s):	Katy Crichton, Freedom to Speak Up Guardian			
Presented by:	Katy Crichton, Freedom to Speak Up Guardian			
History:	N/A			
Status:	☒	**Assurance**	☒	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

This report provides the Board with an update on Freedom to Speak Up (FTSU) activities since the last report to the Board in November 2019 and the implementation of the London Ambulance Service NHS Trust (LAS) FTSU Strategy.

Recommendation(s):

The Board is asked to note the update provided in this report.

Links to Board Assurance Framework (BAF) and key risks:

N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☐
Performance	☐
Financial	☐
Workforce	☐
Governance and Well-led	☐
Reputation	☐
Other	☐
This paper supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

Freedom to Speak Up Quarterly report

Background

1. It is a requirement in the standard NHS contract that NHS Trusts appoint a Freedom to Speak Up (FTSU) Guardian. Guardians can be approached by any worker in confidence, at any time, to discuss concerns about any risk, malpractice or wrongdoing which they believe is harming the service.

2. In July 2018 Katy Crichton was appointed as permanent part time FTSU Guardian to: raise the profile of FTSU across the organisation; continue to deliver a FTSU service across the Trust; and to represent the LAS at national and regional speaking up events. Due to the large volume of new concerns raised in Q2 and Q3 of that year, Katy took on the Guardian role full time in December 2018. Paramedic Erica Greene was recruited into the new part time post of FTSU Co-ordinator in September 2019.

3. This report provides information about FTSU activities that have taken place within the London Ambulance Service NHS Trust (LAS) and nationally since the last Board update in November 2019.

LAS FTSU casework:

4. In line with the standard NHS contract, the LAS is required to report quarterly details of Freedom To Speak Up cases to the National Guardian's Office (NGO). In quarter three 2019/20, 71 cases were raised. By way of comparison there were 118 cases raised during Q1 – Q4 2018-19.

5. The format of the quarterly reporting of LAS cases was set out in the January 2018 report to the Board (ref: TB/17/1616) and is as follows.

   Q3

   - **How many new speaking up cases were raised?**

     71

6. In order to allow better comparison with other English Ambulance Trusts, the **Q2** data by Trust was as follows;

Trust	*Cases*	*Anonymous*	*Pt Safety*	*B&H*	*Detriment*
EMAS	**5**	**5**	**0**	**1**	**0**
EEAST	**6**	**1**	**1**	**2**	**0**
LAS	**66**	**1**	**6**	**14**	**0**
NEAS	**1**	**1**	**0**	**0**	**0**
NWAS	**49**	**5**	**5**	**18**	**0**
SCAS	**23**	**3**	**1**	**2**	**0**
SECAMB	**21**	**3**	**0**	**9**	**1**
SWAST	**9**	**0**	**2**	**2**	**0**
WMAS	**1**	**0**	**1**	**0**	**0**
YAS	**17**	**0**	**1**	**6**	**0**

- **Are there any areas of the service that have featured more than others?**

7. The sources of FTSU concerns are shown in the following table:

Source	*Number of concerns*
Sectors	34
EOC	13
IUC/111	7
Corporate	17
Total	**71**

8. In sectors, a similar number of concerns have been raised in all (range 7-9 per sector) except in the south west (SW) where only two concerns were raised in Q3, despite FTSU presence at all SW sector CEO roadshows. This will be a focus for Q4, with events planned to ensure that staff in this sector have the same awareness of FTSU as other sectors. It is a similar picture for south east London (SEL) integrated urgent care (IUC), so the FTSUG and FTSU coordinator will be visiting in Q4.

9. Again this quarter, it appears that black and minority ethnic (BME) colleagues are more likely to raise concerns than non-BME colleagues, with 24% of total issues raised coming from BME colleagues. In contrast to last quarter, more there were more concerns from male (54%) than female colleagues. It is considered that the volume of concerns raised in 2019/20 will allow significant statistical analysis to be undertaken by area, demographic and type of concern raised and published in the annual report. This may help to understand if there is a pattern of concerns and how issues can be tackled more widely.

- **Any actions taken as a result of investigation into these cases?**

10. In order to triangulate some of the issues that are being raised by international colleagues, there will be FTSU presence at the International Liaison Team meetings. There has also been input from the safeguarding team, Emergency Operations Centre (EOC) senior leadership team, Ambulance operations, fleet and logistics and the quality team in order to resolve issues. This includes the production of new infographics and provision of information to the Serious Incident Assurance and Learning Group regarding ongoing issues such as missed VF.

- **Any themes arising?**

11. In Q3, the main themes of the concerns raised can be broken down as follows *(adds to less than 100% due to rounding)*:

Source	*Percentage of concerns*
Process	38%
Management	15%
Bullying and harassment	25%
Patient safety	7%
Staff safety	10%
Estates issues	3%

12. There has been a number of concerns raised with regard to staff safety and the provision of support by local management teams. This is being worked through with the assistance of senior managers and the wellbeing team to improve communication and the quality and frequency of this support. Communication remains a theme of the 'process' concerns, with staff often not understanding the rationale for policy changes or procedures rather than there being an issue with policy itself.

13. In the July Board meeting, the CEO asked for a breakdown of the proportion of bullying and harassment (B&H) concerns that relate to peers and those for managers to staff. Of the Q3 FTSU concerns that have an element of B&H,(18) 45% were peer-on-peer and 55% were manager to staff. Of the 17 conflict issues that were raised with the Dignity at Work facilitator, 59% were manager to peer and 41% peer-on-peer.

14. Of the 71 concerns raised in Q3, one was raised anonymously. Feedback was obtained for 38 concerns that were closed in the period, all of which answered 'yes' in response to the question 'would you speak up again?' There were nine staff who were part of a group FTSU concern raised that answered 'yes' to the second feedback question 'have you suffered any detriment as a result of speaking up?'. It is an important reflection of their experience that, whilst they felt their situation had been improved overall by raising their concern, the length of time that it took to get a resolution allowed difficult relationships with senior managers to worsen. Alongside the Dignity at Work Facilitator, Amanda Stern, a case review from the People and Culture (P&C) team has been requested to understand how this can be prevented recurring in future. An external investigation addressed the issue that was raised by the group which led to appropriate action being taken in the management team. All of the other 31 members of staff who gave feedback reported they had not suffered any detriment as a result of raising a concern.

15. As of the end of Q3, there are 3 concerns that remain open from 2018/2019 (down from 4 in Q2), 6 from Q1, 12 from Q2 and 38 from Q3 2019/20.

Progress against LAS FTSU Strategy:

Theme 1 - Engaging senior leaders to ensure that FTSU is given appropriate prominence within the Trust

16. What we have said we will do:

a) We will work with the Trust's senior leaders to ensure that they take an interest in the Trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up.

b) We will work with the Trust's senior leaders to ensure that they can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.

c) We will work with the Trust's senior leaders to help them to use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience.

17. What we have done since the last report to the Board:

a) The FTSU Guardian now has monthly meetings with the Chief Executive and Chief Operating Officer and fortnightly with the Director of People and Culture and executive lead for FTSU, the Director of Corporate Governance. She also attends the Workforce Race Equality Standard (WRES) action group and executive leadership team meetings in order to ensure that the themes and trends from FTSU are being shared and acted upon. Both the Chair and the Director of People and Culture have written articles for internal circulation this quarter to encourage staff to use FTSU if they do not feel able to use other channels.

b) The FTSU Guardian is developing KPIs by directorate to ensure that there is transparency regarding how long cases are open for, along with their complexity and themes. This should ensure that the executive team have oversight of the issues in their area and create a better understanding of the learning that can result from FTSU concerns.

c) The Gosport Working Group was established, along with an action plan based on the recommendations of the Report of the Gosport Independent Panel on what happened at Gosport Ware Memorial Hospital, unheeded warnings and the deaths that resulted. The FTSU Guardian also attends the Serious Incident Assurance and Learning Group (SIALG) (to learn from serious incidents) which in turn informs the Quality Oversight Group and the Quality Assurance Committee.

Theme 2 - Ensuring that all members of staff know and understand about FTSU and the role of the Guardian

18. What we have said we will do:

a) We will establish a network of FTSU advocates to support the FTSU Guardian and ensure that dissemination of FTSU information is more widespread.

a) We will have a clear communication plan that tailors and ensures appropriate FTSU communications to different groups of staff.

b) We will ensure that learning from concerns is clearly communicated.

19. What we have done since the last report to the Board:

a) The final two of the 32 advocates received their training in December 2019. 12 (17%) of the concerns in Q3 came via advocates. The advocates receive fortnightly emails and have their own Facebook group for updates. 18 of the advocates attended the FTSU celebration day at HQ in October 2019 and took part in a number of FTSU awareness events to highlight FTSU month.

b) The RIB and LIA now feature regular posts relating to FTSU. The Pulse has now been updated to include a list of all the advocates, information on speaking up and a 'news section'. FTSU now appears in every corporate induction day and is presented by the FTSU Guardian, Co-ordinator or Dignity at Work Facilitator Amanda Stern.

c) Learning from concerns is now published quarterly after Board, and specific examples communicated to the advocates for face to face contacts. The National Guardian's Office (NGO) asked the FTSU Guardian to write a blog with the LAS Chief Operating Officer in relation to FTSU, staff assaults and leadership (see article in Q3 Learning and Actions below) which is to be published in the January NGO Newsletter.

Theme 3 - Ensuring that the systems/process/structures are in place to support raising concerns and responding to these and leaning from them

20. What we have said we will do:

a) We will review our FTSU Policy to ensure that it remains appropriate and easily accessible.

b) We will clarify the systems and processes underpinning the routes through which different claims can be made.

c) We will ensure that there are links between all parts of the organisation where concerns may be raised, to avoid casework being duplicated or missed.

21. What we have done since the last report to the Board:

a) The Guardian is currently working on a more condensed version of the FTSU Policy that will quickly convey the key messages and focus on answering the questions that staff have raised in focus groups about FTSU. This work continues although has not moved forward

this quarter due to capacity. A volunteer familiar with policy work has now come forward to assist with this task.

b) The Guardian attended, and will continue to attend where possible, the Serious Incident Assurance and Learning Group (SIALG) to ensure that there is cross over with other reporting methods including Datix. The Guardian has also sought further information from South Central Ambulance Service NHS Foundation Trust (SCAS) and South East Coast Ambulance Service NHS Foundation Trust (SECAMB) and will incorporate some of this learning into an easy to follow flow chart.

c) The Guardian continues to meet with the Dignity at Work Facilitator. The FTSUG holds , fortnightly meetings with the Director of People and Culture and quarterly meetings with the unions.

Theme 4 - (With the People and Culture Directorate) facilitating cultural change

22. What we have said we will do:

a) We will work with the People and Culture Directorate to ensure that FTSU is reflected in all of the work undertaken to implement the People and Culture Strategy.

b) We will ensure that there are ongoing coherent evaluations of the FTSU environment within LAS.

c) Activities undertaken to establish a picture of the understanding of FTSU within LAS.

23. What we have done since the last report to the Board:

a) The Guardian has been part of the Civility Review steering group, led by Dignity at Work Facilitator Amanda Stern. The Guardian has also met with the Director of People and Culture, with regular meetings to share learning and issues planned in on a fortnightly basis.

b) The FTSU Co-ordinator has developed a new survey to establish the attitudes and knowledge of staff relating to FTSU. This was published in January 2020.

c) The LAS continues to receive external attention for FTSU. In October, the LAS won the National Guardian's Office FTSU index award for most improved NHS Trust in England. In December, the Health Business awards "Ambulance Trust of the Year" with special mention of our FTSU and positive cultural change.

Freedom to Speak Up Month

24. October was national FTSU month and there were a number of events across the Service to celebrate, including a FREEdom to speak up breakfast at Deptford hosted by advocate and paramedic Kirsty Bensberg-Hickmott, FTSU coordinator Erica Greene and advocate Ann Weekes visited NEL IUC and advocate and paramedic Nick Hodgson met crews with information leaflets and sweets at hospitals in South east London. The FTSU Guardian and coordinator also hosted afternoon teas in both EOCs and attended the majority of the CEO roadshows. The main event of the month was the FTSU "celebration" day that took place in the conference room at HQ. Advocates, managers and interested staff came along to hear a number of internal and external speakers give presentations on various aspects of FTSU. This included executive lead Philippa Harding, non-executive lead Fergus Cass, Head of 999 Quality and Continuous Improvement Alison Blakely and Dignity at work facilitator Amanda Stern. There were also talks from SCAS FTSUG Simon Holbrook, and the London Region FTSUGs Chair and vice Chair. The day was extremely well attended and has provided a successful template for an even bigger event next year. Our sincere thank you to the speakers and those who attended.

Q1 2019/20 Learning and Actions:

25. Concerns raised contributed to:

    a) Early resolution of potentially volatile situations through coaching staff to have early courageous conversations or to use managerial channels to raise concerns.
    b) Awareness and improvement of difficult interactions with contractor colleagues.
    c) Resolution of issues that specifically affect international colleagues
    d) Working with union colleagues to resolve rota issues
    e) Highlighting issues with safeguarding processes
    f) Ensuring that senior managers are aware of and reacting to IG breaches
    g) The dismissal of false accusations against some members of staff.

26. As with last quarter's FTSU report to the Board, it should be noted that there are multiple situations where colleagues are using FTSU to find answers that have not been available elsewhere, or where individual situations are being resolved without wider learning occurring. The next stage will be to start translating these smaller learning points into actions that will prevent the same situations occurring in future. Challenges include time pressures on management teams who are assisting to resolve concerns, and a possible lack of enthusiasm to enact wider changes. It will be a focus of FTSU over the next year to promote the ethos of leaders "listening up" to complement the high numbers of staff speaking up. As a small step to promoting listening up, the FTSU Pulse page now has a listening up tab with links to resources that may help both staff and managers understand how they can contribute to positive change.

27. Feedback from Q3

    - "I would absolutely use the system again, but I think that more has to do with your advocacy and follow up, I don't think I'd trust anyone else to be as thorough".
    - "Thank you for keeping my confidentiality and I do feel comfortable enough to speak up again, if and when necessary."
    - "I believe that it is starting to make a difference in the workplace already. Long may your good work continue!"
    - "Answer to your question yes I would definitely speak up again I think the freedom to speak is a great success as this is a great example to what can be achieved"
    - "Thank you so much for all of your efforts in this matter, I really appreciate it and it feels good to know your support is there. Everything you've done sounds like a step in the right direction and I can't thank you enough. "
    - "Yes, the process worked exactly as I hoped it would and will advocate others to use the process."
    - "There was a lot of stress during this whole issue but now I feel the stress has been taken off my shoulders. I would like to say thank you so much. "
    - "I would absolutely use freedom to speak again and highly recommend my colleagues, I have had no repercussions from speaking up"

28. In December 2019, The National Guardian's Office asked the LAS FTSUG and Chief Operating Officer to write an article for their newsletter based on a story about staff assaults in the Evening Standard. Very kindly written with assistance from colleagues in the communications department, the article will go out to staff involved in FTSU in English NHS Trusts and Primary Care and reads as follows;

Katy Crichton, Paramedic and London Ambulance Service FTSU Guardian

Over the past year, Freedom to Speak Up issues raised by London Ambulance Service staff have increased considerably. We saw the same number in the first six months of this financial year as for the whole of last year.

I believe the growing number of workers now feeling confident to speak up is a positive thing which will drive real change to benefit both our staff and our patients.

What are they speaking up about? Patient safety issues are lower down the list of reported concerns. London Ambulance Service staff are generally not afraid to speak up for their patients. Day in and day out, I see them using our reporting systems like Datix, making safeguarding referrals or flagging incidents with managers to make sure they are protected.

So while patient safety is not an area where workers often feel the need for added protection and confidentiality from someone like me, this is not true for cultural concerns around London Ambulance Service processes or behaviour of colleagues.

As an example of culture change, we have a trust-wide focus to make staff feel comfortable to report cases of verbal and physical abuse from the public. These incidents have long been under reported, as we may not be as good at "sticking up" for ourselves as we are for patients. We hope this is getting better - as an organisation we were really proud of paramedic Lizzie who recently waived her right to anonymity and spoke to the Evening Standard about her experience of sexual assault from a patient.

But many of us can become so used to things like verbal abuse – be it over the phone or in person – that it can start to feel normal. Like any long-standing cultural issue, people start to feel there is no point in raising it. Internal work with staff to encourage reporting together and a public media campaign - #notapartofthejob – has been challenging this mind-set. We are starting to see attitudes changing as workers see there is an appropriate response from managers and the judicial system.

The high number of LAS workers now speaking up is testament to the importance that the executive team has placed on it. I have regular meetings with the CEO, COO, Director of People and Culture as well as the executive and non-executive leads for FTSU. I was able to recruit a part time FTSU co-ordinator, paramedic Erica Greene, to support me when the workload became unmanageable for me alone. We have more than 30 FTSU advocates to encourage and help workers to speak up in their area. We routinely use internal channels to promote FTSU and the learning that is taking place as a result of issues raised.

Speaking up is a team effort between workers, managers and unions. Without being complacent, we are doing that part of it well. The next phase is to ensure that we are "listening up" as well as we are speaking up. This means really making use of what we are learning through FTSU and supporting our staff to feel that they are looked after by the Trust as well as we are looking after our patients.

Khadir Meer, London Ambulance Service Chief Operating Officer

On joining LAS in September, I was immediately thrown in to the Chief Executive's six monthly roadshows. I very quickly realised that meeting our staff is in no way straightforward given we operate out of 68 ambulance stations and at least another 10 corporate and support facilities across 650 square miles that is London.

Katy and or Erica came to every roadshow, encouraging staff to 'speak up', listening to concerns, and talking about the actions we had taken in response.

The fact that such a number of issues are being raised is a good thing. We are not unique in the challenges we face. Most of our workforce are band six or below. They work tirelessly to

deliver high quality patient care within the context of the associated high cost of living and travelling in London and this places demands on shift working staff in a 24-hour service. We can only fix problems we know about and FTSU has proved to be a really good way to help the board understand staff experience in all areas of the organisation.

In 2019, the first FTSU index awards by the National Guardian's Office (hyperlink to report) found that with a 17% increase we were the most improved NHS trust in England which shows our speaking up culture is maturing. But translating the concerns into meaningful action and learning is the difficult part. Change takes time and this can be frustrating for staff.

We must ensure our managers at all levels are given the training, development and time to listen and understand the issues that are bought to them, whether it be by staff themselves, the unions or FTSU. Equally important to me is managers feeling empowered to make decisions and have the resources to take action in discussion with staff.

For me, caring for our staff is my foremost priority because if they are not supported I cannot expect them to support and care for our patients effectively.

National Guardian's Office (NGO):

29. The National Guardian's Office asked Freedom to Speak Up Guardians in all Trusts and foundation trusts for information on Freedom to Speak Up cases raised with them in the second quarter of 2019/20. The results are set out below - 97% of trusts have provided data in that quarter.

    Q2 2019/20 data headlines:
    - 3,486 cases were raised to Freedom to Speak Up Guardians / ambassadors / champions
    - 846 of these cases included an element of patient safety / quality of care
    - 1246 included elements of bullying and harassment
    - 127 related to incidents where the person speaking up may have suffered some form of detriment
    - 455 anonymous cases were received
    - 2 trusts did not receive any cases through their Freedom to Speak Up Guardian
    - 220 out of 226 NHS trusts sent returns

30. The NGO is currently focusing on the introduction of FTSU into primary care, and has recruited regional leads for each area to assist with this. The regional lead for London is yet to be appointed. There is a new website that is now separate from the CQC website and is accessible at nationalguardian.org.uk

31. In October, the FTSU Guardian, FTSU Coordinator, NED Fergus Cass and Director of People and Culture attended the National Guardian's Office FTSU index award ceremony to collect the award from Simon Stevens for most improved NHS Trust. The event was also attended by Sir Robert Francis, who spoke about the importance of speaking up and positive cultural change.

32. The FTSU index, introduced this year, is reflective of four questions in the NHS staff survey and is suggested to reflect the FTSU culture of organisations. The measures are taken from an average of how many staff indicate they 'agree' or 'strongly agree' with the following questions;

    - their organisation treats staff who are involved in an error, near miss or incident fairly
    - their organisation encourages them to report errors, near misses or incidents
    - if they were concerned about unsafe clinical practice, they would know how to report it

- they would feel secure raising concerns about unsafe clinical practice

33. The results were taken from staff surveys 2015-2018, during which time the LAS improved from 57% to 75% on the above. This was the biggest improvement for any Trust in England. The ambulance sector average is 74% with the best at 79% (Isle of Wight ambulance service). LAS staff involved with FTSU were invited to an awards ceremony which took place in October 2019.

National Ambulance Network of Guardians (NAN):

34. The National Ambulance Network (NAN) of Guardians meets quarterly to share good practice and provide mutual support. The meetings are held in different regions and include an element of CPD as well as an opportunity to network and share information.

35. In November, the NAN met at SCAS HQ. The group discussed topics such as the case review that has recently taken place in NWAS, a new video that has been produced with the assistance of the LAS communications team aimed at ambulance staff and how the NAN can be more interactive in both the LGBT and BME ambulance conferences.

Conclusion

36. The LAS continues to have a high level of engagement with the NGO, the National Ambulance Network and the London Region Network of Guardians, including ongoing supervision sessions that will assist with research to be fed back to the NGO.

37. The NGO's recent case reviews and guidance to the Board are continuing to demonstrate the value of the Guardian role. There is now an increasing amount of evidence that the Trust has an improving FTSU culture which is being recognised externally.

38. In September a new position of Freedom to Speak Up Co-ordinator was filled via a part time secondment to March 2020.

39. The efforts made by the LAS to expand the reach of the Guardian, promote Freedom to Speak up activities and create and environment in which staff feel safe to raise concerns are reflected in the increased number of concerns raised. There is still more to do with regard to the Trust also promoting a culture of "listening up"

40. The Board is asked to note the contents of this report.

Katy Crichton
Freedom to Speak Up Guardian

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	28 January 2020			
Report title:	CARU Annual Reports			
Agenda item:	Additional report, circulated for information only			
Report Author(s):	Clinical Audit and Research Unit			
Presented by:	Dr Fenella Wrigley, Chief Medical Officer			
History:				
Status:	☐	**Assurance**	☐	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

The Stroke Annual Report 2018-19, Cardiac Arrest Annual Report 2018-19 and STEMI Annual Report 2018-19 are presented to the Board for information.

Recommendation(s):

The Board is asked to note the reports.

Links to Board Assurance Framework (BAF) and key risks:

N/A

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☒
Performance	☒
Financial	☐
Workforce	☐
Governance and Well-led	☐
Reputation	☐
Other	☐
This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☐
Partners are supported to deliver change in London	☐
Efficiency and sustainability will drive us	☐

London Ambulance Service
NHS Trust

Stroke Annual Report 2018/19

December 2019

Produced by:

Clinical Audit and Research Unit,
London Ambulance Service NHS Trust,
8-20 Pocock Street,
London,
SE1 0BW.

✉ CARU.Enquiries@lond-amb.nhs.uk

Contents

London Ambulance Service
NHS Trust

Stroke Overview | 2018-19

12,650
total number of suspected stroke patients

49% 69 years*
51% 71 years*
* mean average

43%
recognised as **stroke** at the point of the 999 call

Diagnostic Bundle

F
A
S
T

99.8% 98.9% 99.5%

☑ 98.6%
received a full diagnostic bundle

Conveyance

99.7%
Conveyed to the most appropriate destination

Timings

999 call to arrive scene
21 mins

Overall on-scene
31 mins

Journey to HASU
18 mins

1 Introduction

This report presents information on the care provided by the London Ambulance Service NHS Trust (LAS) to adult patients (aged 16 and above) who were identified by our clinicians as suffering a suspected stroke.

As part of the on-scene assessment of suspected stroke, LAS clinicians complete a pre-hospital diagnostic bundle which consists of performing the Face, Arm and Speech Test (FAST) and measuring both blood pressure and blood glucose levels. In addition, clinicians need to establish the time of onset of stroke symptoms to help inform treatment decisions at hospital.

Suspected stroke patients are conveyed to one of eight specialist hyper-acute stroke units (HASUs) in London for a Computerised Tomography (CT) scan and treatment. Thrombolysis (one of the treatments available when a stroke has been caused by a blood clot obstructing blood flow to the brain) is most effective if given within 4.5 hours from stroke onset. As such, the London Stroke Network agreed that LAS clinicians would place a pre-alert to the receiving hospital when transporting a suspected stroke patient with a symptom onset within 4.5 hours (for other ambulance services nationally the target is 4 hours). This ensures that the stroke team is ready to receive the patient and undertake definitive assessment.

Data for this report were sourced from the LAS Suspected Stroke Registry, which holds clinical and operational information sourced from the LAS Patient Report Forms (PRFs) completed on-scene by clinicians, the Emergency Operations Centre (EOC) Call Logs and vehicle Mobile Data Terminals (MDTs).

2 Findings

Between 1st April 2018 and 31st March 2019, LAS clinicians attended **12,650** suspected stroke patients. This is an increase of 485 patients (4%) compared to last year.

2.1 Patient demographics

- Just over half of patients (**51%**, n=6,513) were **female.**
- The average age was **70 years**, with males being on average 2 years younger than females.

2.2 Call information

During the 999 call, Emergency Call Handlers (ECHs) use a set of pre-triage questions to assess the severity of the patient's condition. Based on this information, calls are then assigned different categories and response targets. As shown in Figure 1, stroke presents in a number of different ways at the point of the 999 call.

- Stroke was recognised as the chief complaint for **43%** of patients.
- The majority of calls (79%, n=9,809) were made directly by members of the **public**.
- Healthcare professional admissions (9%, n=1,166) and calls passed to the LAS from 111 providers (13%, n=1,675) accounted for the remaining 22% (n=2,841) of calls. (Please note the total percentages do not equal 100% due to rounding.)

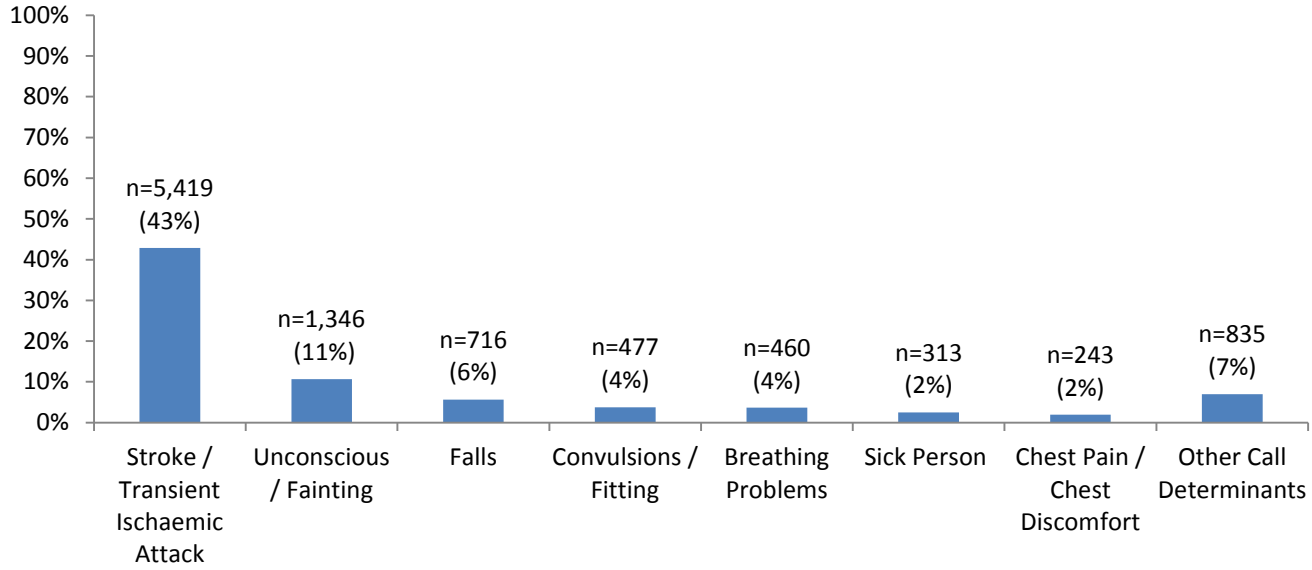


Figure 1: Chief complaints from emergency calls from members of the public who dialled 999 directly

2.3 Response categories

All calls are categorised into five groups depending on the seriousness of the patient's condition (see table below). Each category has a response time defined by the NHS England's Ambulance Response Programme (ARP), designed to ensure that patients receive the most clinically appropriate response. Stroke patients require timely intervention at a specialist centre and therefore need the quick dispatch of a vehicle capable of conveying them to hospital. The majority of patients calling with stroke symptoms will receive a Category 2 response which triggers the dispatch of an ambulance.

Response standards and ARP clock start and stop times are presented below.

<table>
<tr><th rowspan="2">Category</th><th colspan="2">Response standard (minutes)</th><th rowspan="2">Definitions</th></tr>
<tr><th>Mean</th><th>90th centile</th></tr>
<tr><td>Category 1

(Life threatening)</td><td>7</td><td>15</td><td><u>Clock start</u>
The earliest time that:
• the call is assigned a chief complaint; or
• the first resource is dispatched; or
• 30 seconds from the call connecting.
<u>Clock stop</u>
The arrival of the first LAS resource (whether a solo responder or an ambulance).</td></tr>
<tr><td>Category 2 (Emergency)</td><td>18</td><td>40</td><td rowspan="4"><u>Clock start</u>
The earliest time that:
• the call is assigned a chief complaint; or
• the first resource is dispatched; or
• 240 seconds from the call connecting
<u>Clock stop</u>
The arrival of the first LAS vehicle able to transport the patient to hospital.</td></tr>
<tr><td>Category 3
(Urgent)</td><td colspan="2">120 (90th centile)</td></tr>
<tr><td>Category 4
(Less urgent)</td><td colspan="2" rowspan="2">180 (90th centile)</td></tr>
<tr><td>Category 5
(Hear and Treat)</td></tr>
</table>

2.3.1 LAS Response Times

Category	n^ (%)	Response time (minutes)		
		Mean	Median	90th Centile
Category 1	928 (8.1%)	7	7	12
Category 2	9,124 (79.4%)	18	14	36
Category 3	1,226 (10.7%)	47	26	103
Category 4	177 (1.5%)	50	41	93
Category 5~	29 (0.3%)	49	26	104
Overall	**11,484**	**21**	**14**	**42**

^Healthcare Professional admissions (n=1,166) are excluded from the response time figures as they request a response within the specific time frame.
~ Category 5 was introduced in November 2018.

<u>Table 1: Call categories and response times</u>

- The majority (**79.4%,** n=9,124) of calls were allocated a **Category 2** response.
- Mean response times across all categories were in line with the targets (see Table 1).
- The overall average response time for all suspected stroke patients was **21 minutes,** which was **6 minutes faster** than last year.

2.4 First Vehicle on scene

Category 1 calls will routinely receive a solo responder (via car or motorcycle) who will arrive on scene quickly to provide lifesaving interventions whilst awaiting the arrival of an ambulance capable of transporting the patient to hospital. For lower category calls, including Category 2 (the majority of stroke calls), the main objective is to dispatch an ambulance manned by two clinicians who can assess and transport the patient to hospital. However, when there is no ambulance available for prompt dispatch, these patients may first receive a solo responder who can provide a timely face to face assessment and begin the assessment and treatment where possible.

First Vehicle on Scene	Call Category					Total
	C1	C2	C3	C4	C5	
Conveying Ambulance	293 (31%)	9,186 (91%)	1,151 (93%)	311 (96%)	24 (83%)	10,965 (87%)
Other Vehicle	638 (69%)	944 (9%)	85 (7%)	13 (4%)	5 (17%)	1,685 (13%)
Total	931	10,130	1,236	324	29	12,650

Table 2: Call category broken down by first vehicle on scene

2.5 On-scene times

From the arrival of:	n^	On-scene times (minutes)		
		Mean	Median	90th Centile
First arriving vehicle	12,599	31	29	49
First conveying ambulance		29	27	46

^Patients who refused conveyance to hospital (n=51) are excluded from on-scene time figures.

Table 3: On-scene times

- For the majority of calls (**87%**, n=10,965) a conveying **ambulance** was the first vehicle to arrive on scene. For **13%** of cases (n=1,685), another vehicle such as a car or motorcycle was first on scene.
- The overall mean **on-scene** time (from first vehicle arriving) was **31 minutes,** which is a 3 minute improvement from last year.
- When measured from the arrival of the first ambulance, the mean on-scene time was 29 minutes, which is consistent with last year.

2.5 Patient assessment and care

2.5.1 Time of symptom onset

When assessing a suspected stroke patient, LAS clinicians establish the history of the event which includes ascertaining, if possible, the time that stroke symptoms started. This helps to determine if the patient is within the 4.5 hour window for thrombolysis treatment at hospital.

Time of symptom onset	n (%)
Within 4.5 hours	7,339 (58.0%)
Over 4.5 hours	1,485 (11.7%)
Unknown	3,756 (29.7%)
Not documented	70 (0.6%)

Table 4: Onset of symptoms

- 99.4% (n=12,580) of patients either had the time of onset of stroke symptoms recorded or it was reported that the time was unknown (e.g. the patient woke up with stroke symptoms).
- The majority of suspected stroke patients (**58%,** n=7,339) had symptom onset **within 4.5 hours**.

2.5.2 Diagnostic bundle compliance

The pre-hospital stroke diagnostic bundle consists of FAST completion and measurements of blood glucose and blood pressure.

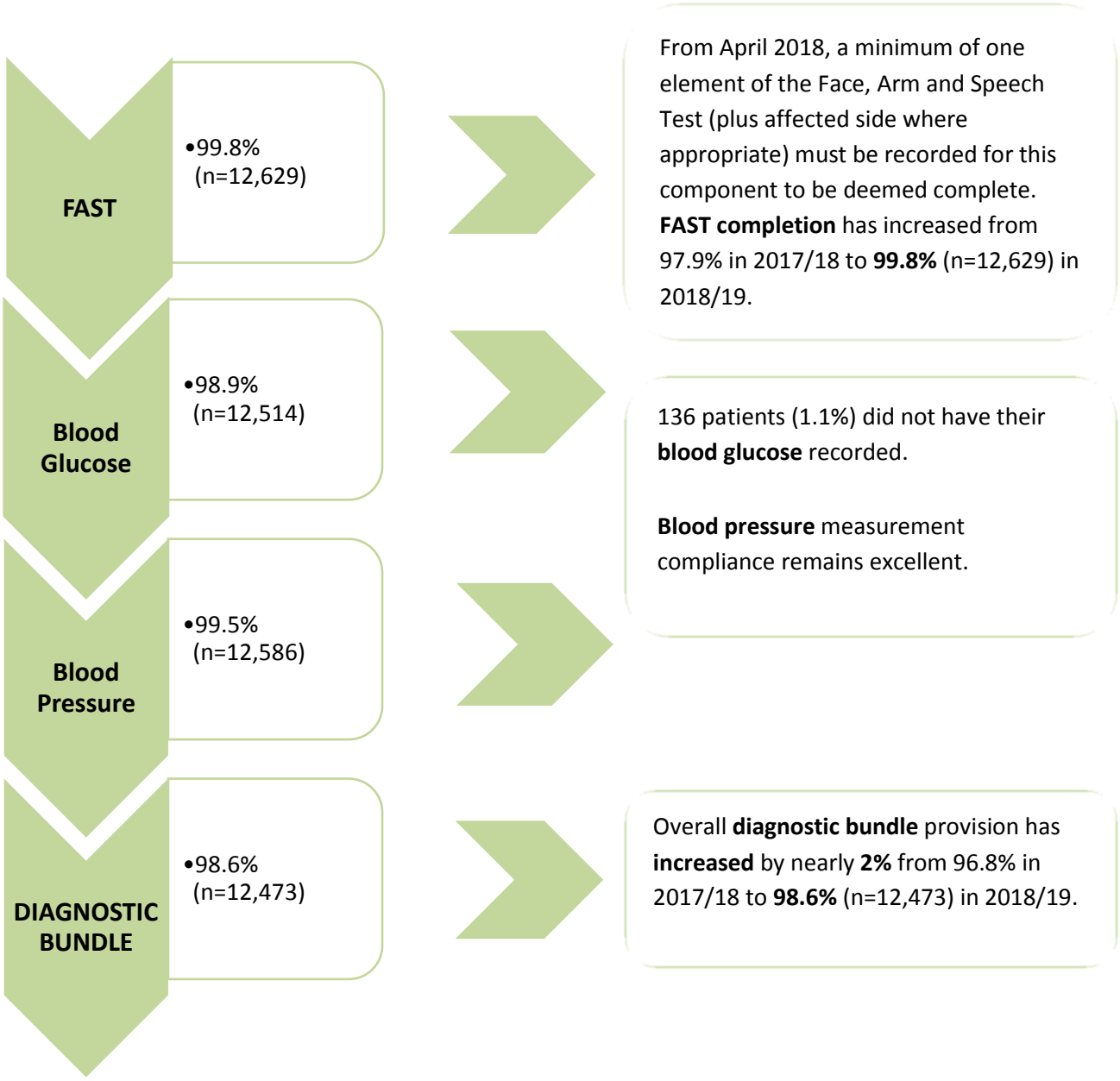


Figure 2: Diagnostic bundle administration

2.6 Conveyance

Suspected stroke patients in London should be conveyed to a Hyper Acute Stroke Unit (HASU) for specialist care. In some instances, the patient may be transported to an Emergency Department (ED) - for example, if their condition is considered unstable by the LAS clinicians or if a Health Care Professional has arranged admission to a hospital without HASU facilities.

2.6.1. Destination of patients

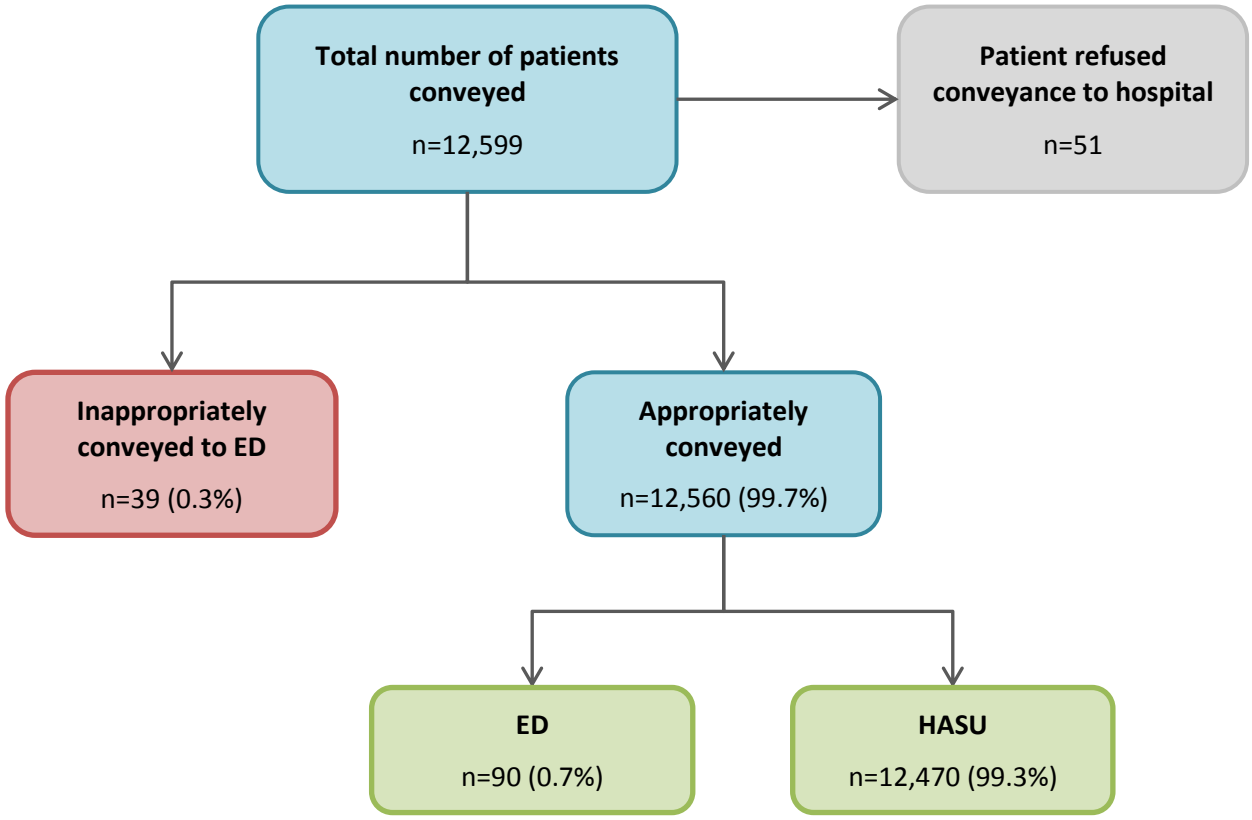


Figure 3: Patient destination

- The majority of suspected stroke patients (**99.7%,** n=12,560) were conveyed to **the most appropriate destination** for their condition. **99.3%** (n=12,470/12,560) were conveyed to a **HASU.**
- Of the 90 patients appropriately conveyed to an ED, 24 (27%) were deemed too clinically unstable to travel to a HASU and 15 (17%) were taken to a different hospital as requested by the Healthcare Professional who arranged the transport.

2.6.2 HASU utilisation

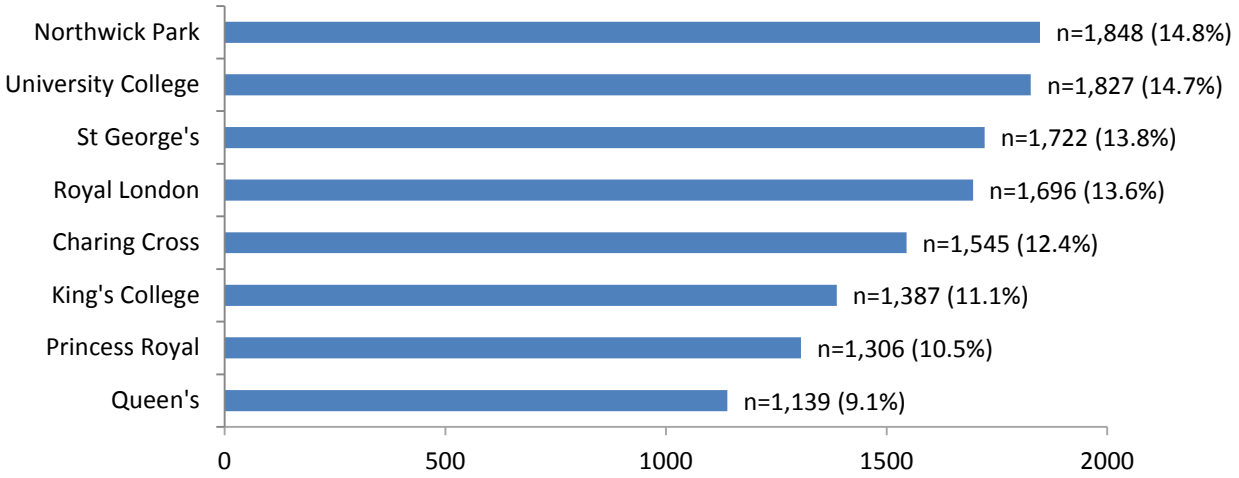


Figure 4: Number of patients conveyed to each HASU

- The majority of patients were conveyed to **Northwick Park HASU** (14.8**%**, n=1,848), closely followed by University College Hospital HASU (n=14.7%, n=1,827).

2.7 Call to hospital and Journey times

When symptom onset occurs within 4.5 hours, patients are transported to a HASU with blue lights and sirens and a pre-alert call is placed to the stroke team. Patients whose symptoms are older than 4.5 hours are conveyed under normal driving conditions.

Destination		999 call – arrive hospital, minutes				Leave scene – arrive hospital, minutes			
		n^†	Mean	Median	90th centile	n^	Mean	Median	90th centile
HASU	All HASU patients	11,339	68	61	103	12,470	18	15	31
	Symptoms onset ≤4.5 hours	6,775	61	56	88	7,300	15	14	25
Patients conveyed to an ED		97	85	74	127	129	17	15	29
Overall		11,436	69	61	103	12,599	18	15	31

^ Non-conveyed patients are excluded from these figures.

†Healthcare Professional admissions are excluded from these figures.

Table 5: Journey and call to hospital times

- The mean **journey time** to hospital for all suspected stroke patients was **18 minutes**.
- The mean journey time to a HASU was **quicker** by **3 minutes** for those whose symptom onset was **within 4.5 hours**. This is consistent with last year's figures and remains well within the 30 minutes target set by the London Stroke Network.
- The mean 999 call to arrival at HASU time for those with a symptom onset **within 4.5 hours** was **61 minutes**, which is a one minute improvement on last year.
- The mean time from **999 call to arrival at a HASU** for all HASU patients was **68 minutes**. This is **4 minutes faster** than last year (72 minutes).

3 Summary

The findings of this report show that the LAS has continued to provide excellent care to suspected stroke patients in London over the year, despite the 4% increase in the number of suspected stroke patients seen and the rise in demand for ambulance services overall.

Our clinicians provided a comprehensive assessment, as demonstrated by excellent diagnostic bundle compliance, and ensured that nearly all patients were transported to the most appropriate destination for their condition.

Our faster average response time this year means that suspected stroke patients are generally being responded to more quickly by our clinicians and being taken more rapidly to a hospital for definitive assessment and treatment.

4 Looking ahead

- We will continue to reduce further time spent on-scene and reiterate the importance of prompt transport to hospital for all suspected stroke patients.
- We will continue to highlight instances where the patient was not conveyed to an appropriate destination for investigation and feedback to staff.
- Details of all incidents where a full diagnostic bundle was not provided to the patient will continue to be shared with local management teams for feedback and on-going education.
- The LAS will continue to submit data to NHS England as part of the Ambulance Quality Indicators programme to enable benchmarking against, and learning from, other ambulance services across the country.
- As of April 2019, the LAS joined the Sentinel Stroke National Audit Programme (SSNAP) Ambulance Linkage Project. SSNAP measures the quality of stroke care across the NHS. This will enable the LAS to source data about the hospital diagnosis and treatment provided to our stroke patients and will allow reporting of outcomes to provide further opportunities to enhance the stroke care provided by our clinicians.

Appendix 1: Incident information by area (broken down by the Clinical Commissioning Group❖)

CCG^	Journey times to a HASU (minutes)		Call to arrival at HASU (minutes)		Call to HASU for patients potentially eligible for thrombolysis (minutes)	
	n#	Mean (Median)	n~	Mean (Median)	n*~	Mean (Median)
Barking and Dagenham	302	13 (11)	289	58 (53)	172	54 (51)
Barnet	505	24 (21)	452	79 (70)	277	71 (64)
Bexley	388	26 (24)	343	78 (72)	203	73 (66)
Brent	543	16 (14)	491	68 (59)	273	56 (53)
Bromley	518	13 (12)	472	61 (56)	288	55 (50)
Camden	289	12 (10)	262	61 (54)	154	54 (51)
Central London	298	13 (11)	273	62 (54)	179	53 (49)
City and Hackney	357	15 (13)	324	67 (58)	200	61 (56)
Croydon	633	21 (18)	585	75 (66)	342	65 (60)
Ealing	571	18 (16)	521	67 (59)	325	60 (56)
Enfield	441	36 (31)	403	92 (83)	247	82 (75)
Greenwich	352	27 (24)	322	78 (72)	195	68 (65)
Hammersmith and Fulham	297	10 (8)	251	56 (52)	143	50 (46)
Haringey	305	26 (22)	282	82 (73)	162	72 (63)
Harrow	391	11 (11)	341	60 (54)	209	54 (49)
Havering	497	10 (10)	462	56 (51)	266	49 (47)
Hillingdon	476	24 (21)	428	80 (72)	269	71 (66)
Hounslow	406	21 (19)	376	71 (63)	239	63 (58)
Islington	334	15 (13)	305	75 (63)	170	64 (59)
Kingston	223	21 (19)	205	68 (62)	124	65 (60)
Lambeth	397	12 (10)	360	62 (56)	189	54 (51)
Lewisham	376	18 (16)	336	67 (61)	193	58 (54)
Merton	299	12 (11)	272	58 (53)	160	50 (48)
Newham	396	18 (16)	372	69 (60)	233	63 (57)
North West Surrey	1	19 (19)	1	49 (49)	no patients	
Redbridge	414	18 (16)	384	68 (60)	239	61 (57)
Richmond	292	23 (22)	268	75 (68)	159	70 (63)
Southwark	445	11 (10)	396	60 (54)	214	52 (48)
Surrey Downs	1	21 (21)	1	54 (54)	1	54 (54)
Sutton	347	18 (16)	319	62 (59)	202	57 (54)
Tower Hamlets	342	9 (8)	313	60 (54)	175	56 (51)
Waltham Forest	368	26 (23)	339	78 (72)	215	69 (64)
Wandsworth	368	13 (11)	330	60 (56)	183	52 (49)
West London	293	13 (12)	257	62 (55)	172	57 (52)
LAS wide	**12,470**	**18 (15)**	**11,339**	**68 (61)**	**6,775**	**61 (56)**

❖ Based on the location of the incident
^ For 6 cases the CCG information was unavailable
 # Non-conveyed patients are excluded from the figures
~ Health Care Professional admissions are not included
** Patients whose symptoms were less than 4.5 hours old when leaving the scene of the incident*

Appendix 2: Care of patients by LAS Group Station

Station Groups	On-scene times (from first attending resource) (minutes)		Care bundle		Journey time to a HASU (minutes)	
	n*	mean (median)	n	%	n*	mean (median)
Homerton	669	32 (30)	671	98.7%	666	14 (12)
Newham	908	31 (28)	910	98.7%	899	19 (17)
Romford	908	29 (27)	911	99.2%	906	13 (12)
North East	2,485	31 (28)	2,492	98.9%	2,471	15 (13)
Camden	531	32 (30)	532	98.9%	525	14 (12)
Edmonton	710	32 (28)	713	99.2%	695	31 (27)
Friern Barnet	491	33 (30)	494	99.4%	483	25 (22)
North Central	1,732	32 (29)	1,739	99.1%	1,703	24 (21)
Brent	1026	30 (26)	1032	99.6%	1023	15 (13)
Fulham	673	28 (26)	676	98.7%	669	13 (11)
Hanwell	786	29 (26)	789	98.9%	779	21 (19)
Hillingdon	370	30 (25)	371	99.2%	362	25 (21)
Westminster	244	30 (28)	245	99.2%	240	14 (12)
North West	3,099	29 (26)	3,113	99.1%	3,073	17 (15)
Bromley	769	31 (28)	770	99.2%	764	16 (15)
Deptford	1148	32 (30)	1154	99.0%	1141	13 (11)
Greenwich	652	31 (29)	654	99.1%	639	27 (24)
South East	2,569	32 (29)	2,578	99.1%	2,544	17 (15)
Croydon	502	31 (29)	503	98.2%	497	20 (17)
New Malden	397	32 (29)	402	99.3%	394	21 (19)
St Helier	459	30 (28)	461	98.0%	459	17 (15)
Wimbledon	523	30 (27)	526	98.9%	519	16 (14)
South West	1,881	31 (28)	1,892	98.6%	1,869	18 (16)
PAS & VAS	273	35 (31)	274	98.2%	269	16 (14)
Other LAS†	560	32 (29)	562	90.9%	541	18 (16)
LAS-Wide	**12,599**	**31 (28)**	**12,650**	**98.6%**	**12470**	**18 (15)**

** Non-conveyed patients are excluded from the figures.*

† *Includes Hazardous Area Response, Special Events, Tactical Response Units and Training.*

London Ambulance Service
NHS Trust

Cardiac Arrest Annual Report: 2018/19

December 2019

Produced by:

Clinical Audit and Research Unit,
London Ambulance Service NHS Trust,
8-20 Pocock Street,
London,
SE1 0BW.

✉ CARU.Enquiries@lond-amb.nhs.uk

Contents

Cardiac arrest overview 2018/19 infographic

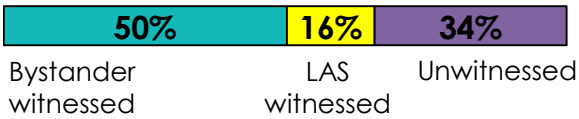
London Ambulance Service NHS Trust

Cardiac Arrest Overview | 2018-19

10,152
Total patients seen

39%
Had resuscitation attempted

65% 61 years*
35% 67 years*
*Median age

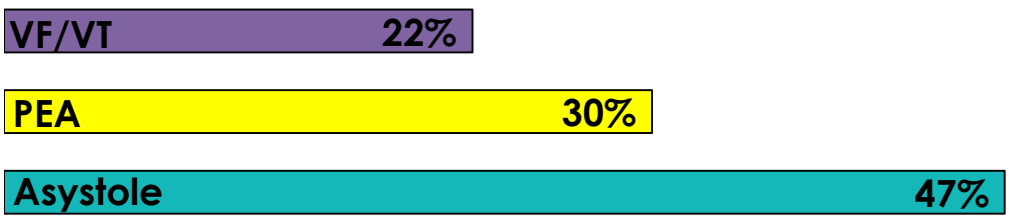


999 call to scene → 07:28

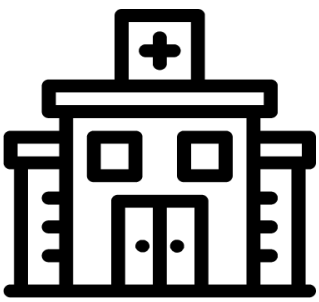
999 call to CPR → 09:35

999 call to defibrillation → 10:38

Initial Rhythm



	Overall		Utstein
ROSC to hospital	35.7%		62.6%
Survival	10.8%		36.6%



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1 Introduction

This report presents key information regarding the response and treatment that out-of-hospital cardiac arrest patients received from the London Ambulance Service NHS Trust (LAS), the presenting factors that may have affected survival, and the outcome of these patients.

10,152 patients suffered an out-of-hospital cardiac arrest between 1st April 2018 to 31st March 2019 and our clinicians attempted to resuscitate **4,004** (**39.4**%) of these patients. Resuscitation efforts were not undertaken for **6,148** (**60.6**%), with 4,386 of these patients being recognised as deceased on arrival of the clinician, and the remaining 1,762 had in place a Do Not Attempt Cardio-Pulmonary Resuscitation (DNA-CPR) order, advanced directive or equivalent, or the patient's death was expected.

Data were sourced from the LAS's Cardiac Arrest Registry, which captures information from a range of clinical and operational sources including: Patient Report Forms (PRFs), vehicle Mobile Data Terminals (MDTs), emergency call logs and defibrillator data. Survival to hospital discharge information was collected from hospital patient records and national databases.

The following information refers to the clinical care provided and the outcomes of the **4,004** patients where resuscitation was attempted.

2 Profile of arrests

Gender □, n (%)	
Male	2,602 (65.0)
Female	1,401 (35.0)
Unknown	1 (<0.1)

Age, mean (median) in years	
Overall	63 (67)
Male	61 (64)
Female	67 (72)

Race, n (%)	
White	2,386 (59.6)
Black	344 (8.6)
Asian	334 (8.3)
Mixed	17 (0.4)
Other	176 (4.4)
Unable to obtain	694 (17.4)
Not documented	53 (1.3)

Location □, n (%)	
Private location	**2,918 (72.9)**
Home	2,727 (93.5)
Care home	191 (6.5)
Public location	**1,086 (27.1)**
Street	434 (40.0)
Work	103 (9.5)
Healthcare facility	182 (16.7)
Public transport	77 (7.1)
Social venue	52 (4.8)
Shop	36 (3.3)
Park/wood/river	41 (3.8)
Hotel/Hostel	40 (3.7)
Leisure centre/sports club	39 (3.6)
Airport	15 (1.4)
Other	67 (6.2)

Peak occurrence	
Time of day (hh:mm)	08:00-11:59 23.3% (n=932)
Day	Sunday 15.3% (n=613)
Month	December 10.5% (n=421)

Chief complaints at the 999 call, n (%)□	
Cardiac arrest	2,085 (52.1)
Unconscious/fainting	448 (11.2)
Breathing problems	398 (9.9)
Falls	162 (4.0)
Other	780 (19.5)
111 NHS Transfers	73 (1.8)
HCP Admissions	58 (1.4)

Table 1: Profile of cardiac arrests where resuscitation was attempted (n=4,004)

□ *The total percentages do not equal 100% due to rounding.*

3 LAS response times

3.1 Response time by call category

Calls received via 999 are triaged, according to severity, from Life Threatening (Category 1) to suitable for 'Hear & Treat' (Category 5). A set of pre-triage questions help the early recognition of life-threatening conditions by call takers (e.g. ineffective breathing may indicate cardiac arrest), and enable the rapid dispatch of ambulance resources. Each category of call has a target response time, as defined by NHS England's Ambulance Response Programme (ARP)[1], presented in the table below.

<table>
<tr><th rowspan="2">Category</th><th colspan="2">Response standard (mins)</th><th rowspan="2">Definitions</th></tr>
<tr><th>Mean</th><th>90th centile</th></tr>
<tr><td>Category 1
(Life threatening)</td><td>7</td><td>15</td><td><u>Clock start</u>
The earliest time that:
• the call is assigned a chief complaint; or
• the first resource is dispatched; or
• 30 seconds from the call connecting.
<u>Clock stop</u>
The arrival of the first LAS resource (whether a solo responder or an ambulance).</td></tr>
<tr><td>Category 2
(Emergency)</td><td>18</td><td>40</td><td rowspan="4"><u>Clock start</u>
The earliest time that:
• the call is assigned a chief complaint; or
• the first resource is dispatched; or
• 240 seconds from call connecting.
<u>Clock stop</u>
The arrival of the first LAS vehicle able to transport the patient to hospital.</td></tr>
<tr><td>Category 3
(Urgent)</td><td colspan="2">120 (90th centile)</td></tr>
<tr><td>Category 4
(Less urgent)</td><td colspan="2" rowspan="2">180 (90th centile)</td></tr>
<tr><td>Category 5
(Hear & Treat)</td></tr>
</table>

Category	n (%)	Mean	Median	90th Centile
Category 1	3,047 (76.1)	7	6	10
Category 2	792 (19.8)	16	13	31
Category 3	144 (3.6)	20	13	48
Category 4	17 (0.4)	57	41	114
Category 5^	4 (0.1)	26	15	50
Overall	**4,004**	**9**	**7**	**16**

<u>Table 2: Response times by category (minutes)</u>

^ *Category 5 replaced Category C4H from November 2018. Patients allocated Category 5 are mainly managed by the LAS Clinical Hub as they are often suitable to be best dealt with via Hear and Treat.*

3.2 Key time intervals

Time interval	Median time
999 call^ – arrive on scene+	07:28
999 call^ – LAS CPR*	09:35
999 call^ – LAS defibrillation*~	10:38

Table 3: Median time intervals from 999 call (minutes)

^ Time the 999 call was connected to the Emergency Medical Dispatcher (EMD)
+ Time from 999 call to the arrival of the first dispatched resource arriving on scene.
** Excludes LAS witnessed arrests.*
~ Based on an initial rhythm of VF/VT.

- Over three-quarters **(76.1%)** of patients received a **Category 1** response. The mean response was **7 minutes** for those patients allocated to **Category 1** which meets the national target.
- For **all** cardiac arrest patients, the mean time taken for a response to arrive was **9 minutes** overall.
- The median time from 999 call to LAS CPR was **9.5 minutes** whilst the median time to defibrillation was **10.5 minutes**.

4 Bystander interventions

4.1 Bystander witnessed and CPR rates

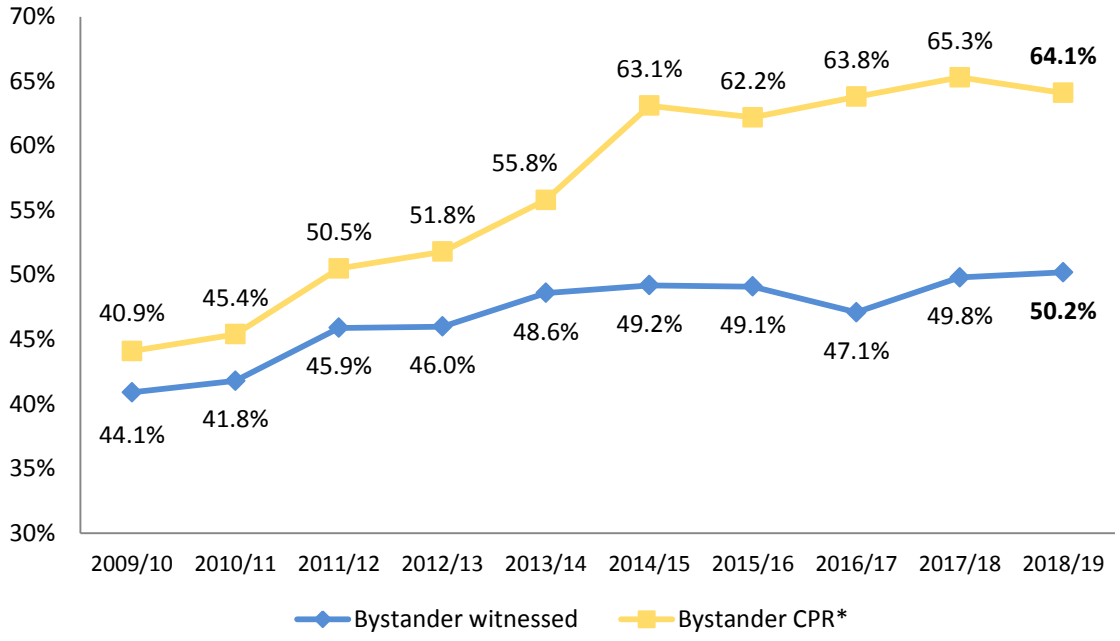

Figure 1: Bystander witnessed arrests and bystander CPR by year

**Excludes LAS witnessed arrests*

- **Bystander witnessed** rates are the **highest** observed to date with more than **half** (50.2%, n=2,012) of cardiac arrests where resuscitation was attempted being **bystander witnessed**.
- The number of patients receiving **bystander CPR** decreased slightly by 1.2% to **64.1%** (n=2,166) but this still represents an increase on all years preceding 2017/18.

4.2 Public Access Defibrillator (PAD)

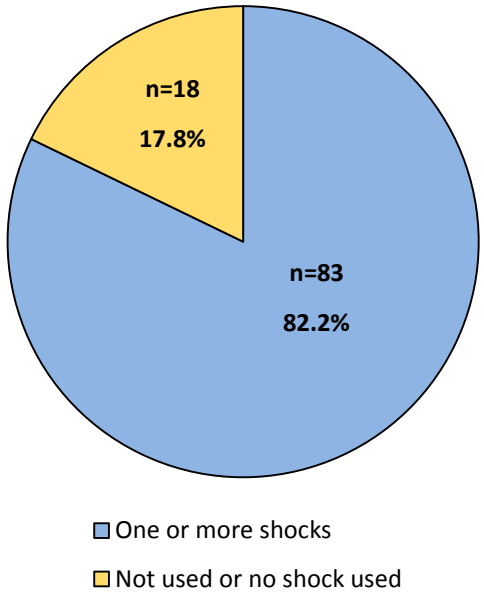

Figure 2: Deployment of a PAD

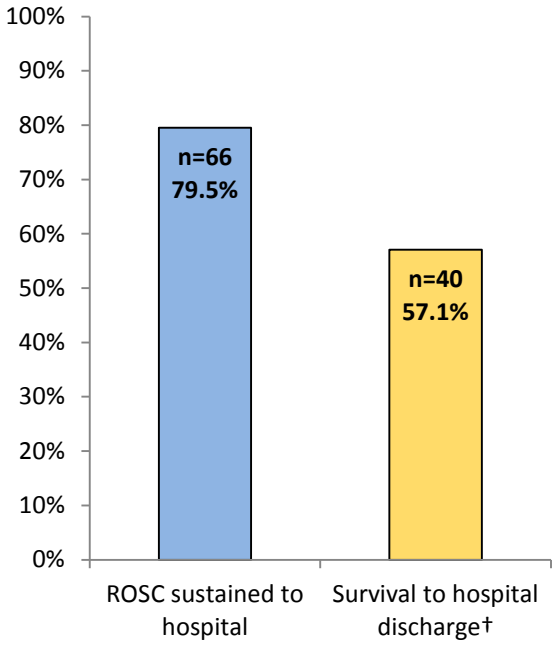

Figure 3: Outcomes where PAD was used

† *Excludes 13 patients with unknown outcomes.*

- A PAD was deployed for 101 cardiac arrests, with **one or more shocks** being delivered by members of the public in **83** cases.
- Of the 83 patients where a PAD was used to deliver a shock:
  - **89.2%** arrests (n=74) were **bystander witnessed** - a 5.7% decrease compared to last year.
  - **All** patients received **bystander CPR**.
  - **79.5%** (n=66/83) had **ROSC** sustained to hospital (14.9% increase from last year).
  - **Survival** to hospital discharge was **57.1%** (n=40/70) - an increase of 5.8% compared to last year (51.3%).

5 Clinical Presentation

5.1 Aetiology

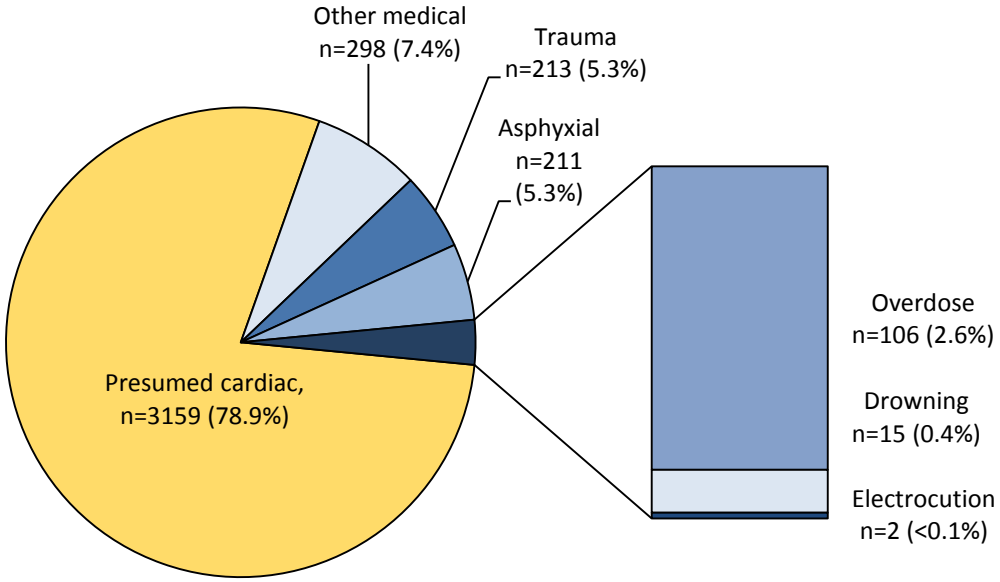

Figure 4: Breakdown of patient aetiology

□ *The total percentages do not equal 100% due to rounding.*

- **Presumed cardiac** aetiology remains the predominant cause of cardiac arrest (78.9%)

5.2 Initial Rhythm

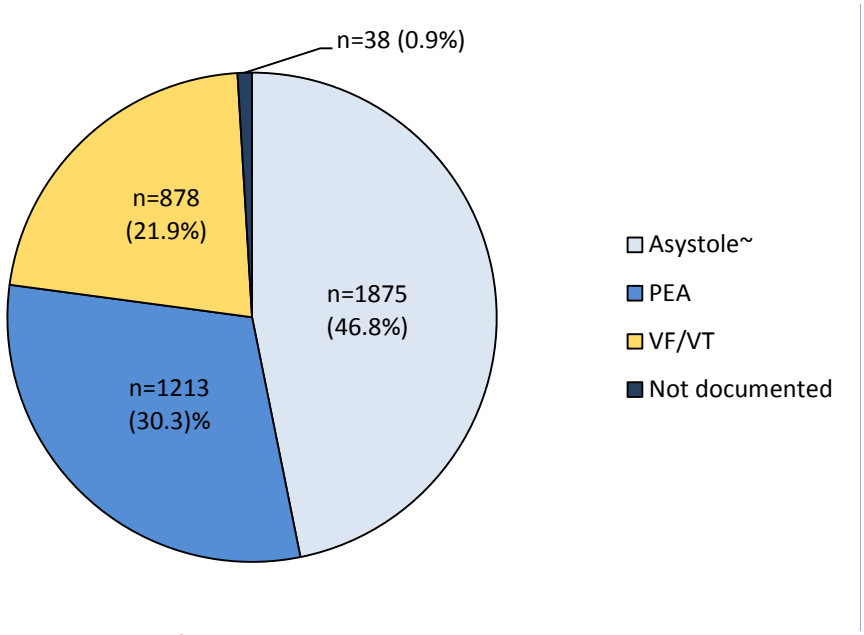

Figure 5: Breakdown of initial arrest rhythm

~ Includes paediatric bradycardia (n=1).

The total percentages do not equal 100% due to rounding.

- Despite seeing a 3.3% decrease from last year, **Asystole (46.8%)** remains the predominant initial rhythm.
- **VF/VT** has increased by 1.6% from 20.3% to **21.9%** this year which is in line with an upward trend over the past five years.

6 Outcomes

6.1 Conveyance

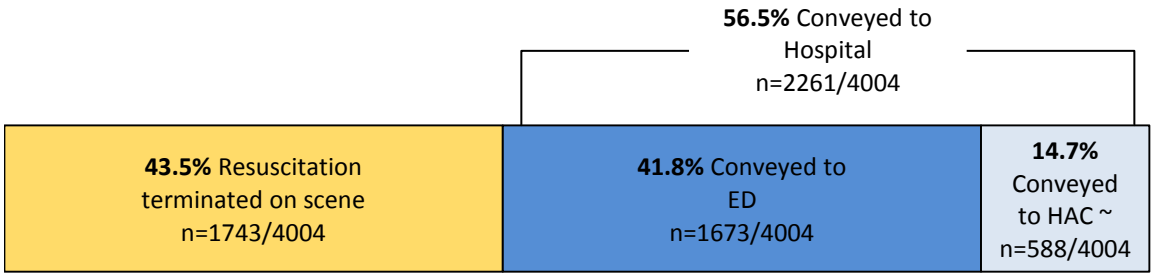

Figure 6: Breakdown of conveyance by destination

~ Includes all patients regardless of whether a STEMI was identified.

6.2 ROSC and Survival

ROSC sustained to hospital arrival and survival to discharge figures are reported for two groups:

1. **Overall group**: all patients where resuscitation was attempted.

2. **Utstein comparator group**[2,3]: a sub-group of patients for whom resuscitation was attempted following a cardiac arrest of a presumed cardiac cause, which was bystander witnessed, and presented in a shockable rhythm (see appendix 3).

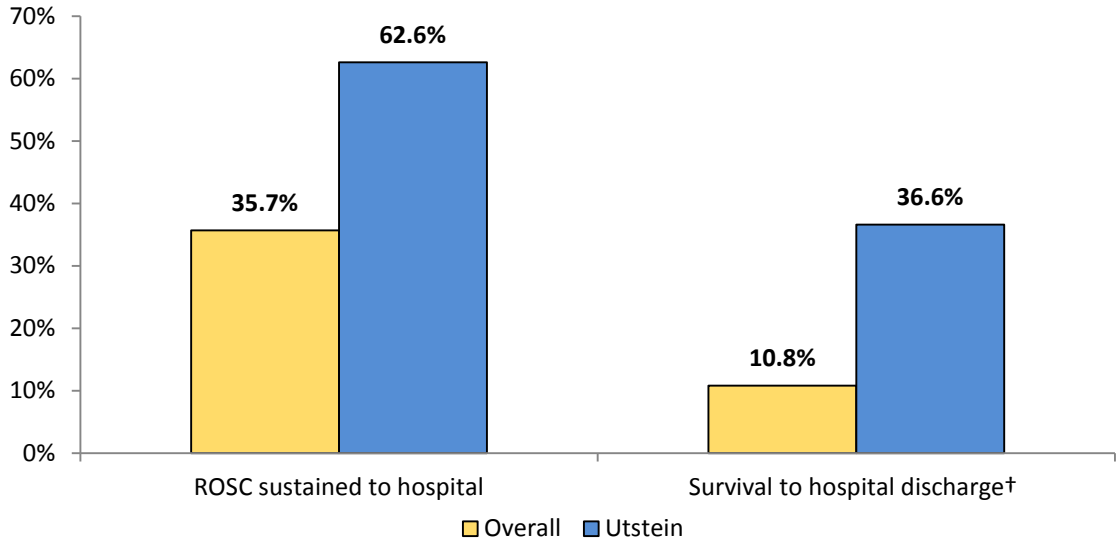

Figure 7: ROSC sustained to hospital and survival to hospital discharge for all patients where resuscitation was attempted ('overall') and the Utstein comparator group

† Unknown outcomes excluded from the overall (n=128) and Utstein (n=31) group

- **ROSC** to hospital and **survival** to discharge rates, for both the overall and Utstein groups, are the **highest** figures reported to date.
- **Overall ROSC** to hospital increased by 3.2% to **35.7%** (n=1,428/4,004; see Figure 8).
- **Overall survival** to hospital discharge increased by 1.4% to **10.8%** (n=419/3,876), up from 9.4% last year.
- For the **Utstein** comparator group, **ROSC** sustained to hospital arrival saw a marked increase of 6 % to **62.6%** (n=353/564).
- The **Utstein survival** rate of **36.6%** (n=195/533) is a 4.7% increase from last year (see Figure 9).

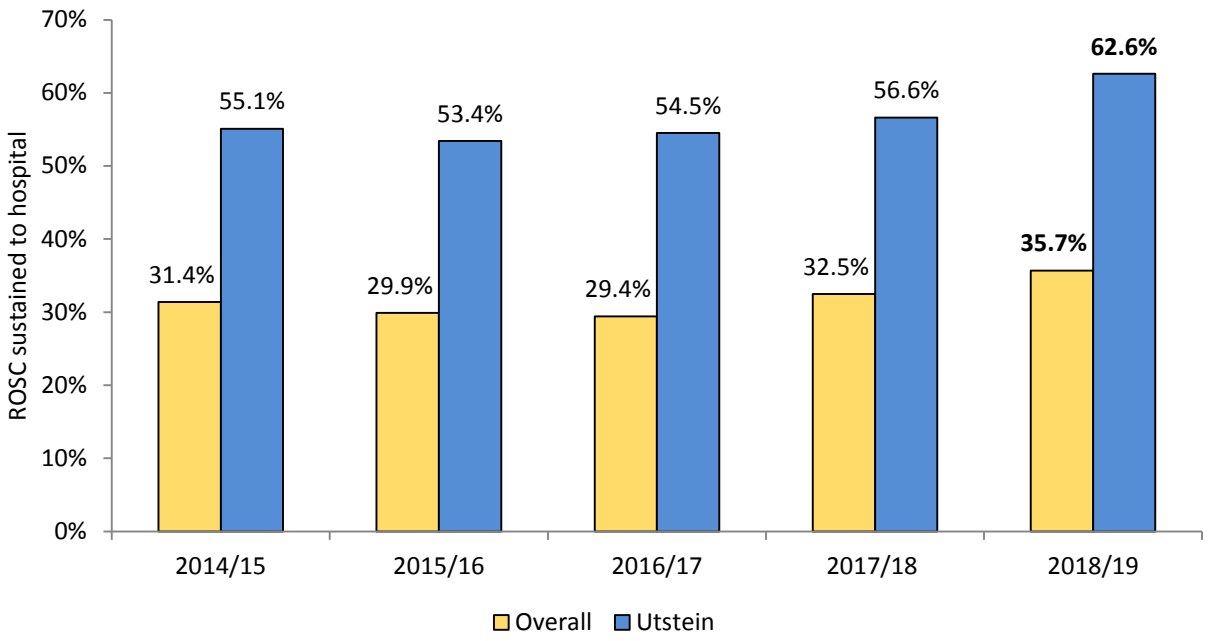

Figure 8: ROSC sustained to hospital per year for all patients where resuscitation was attempted

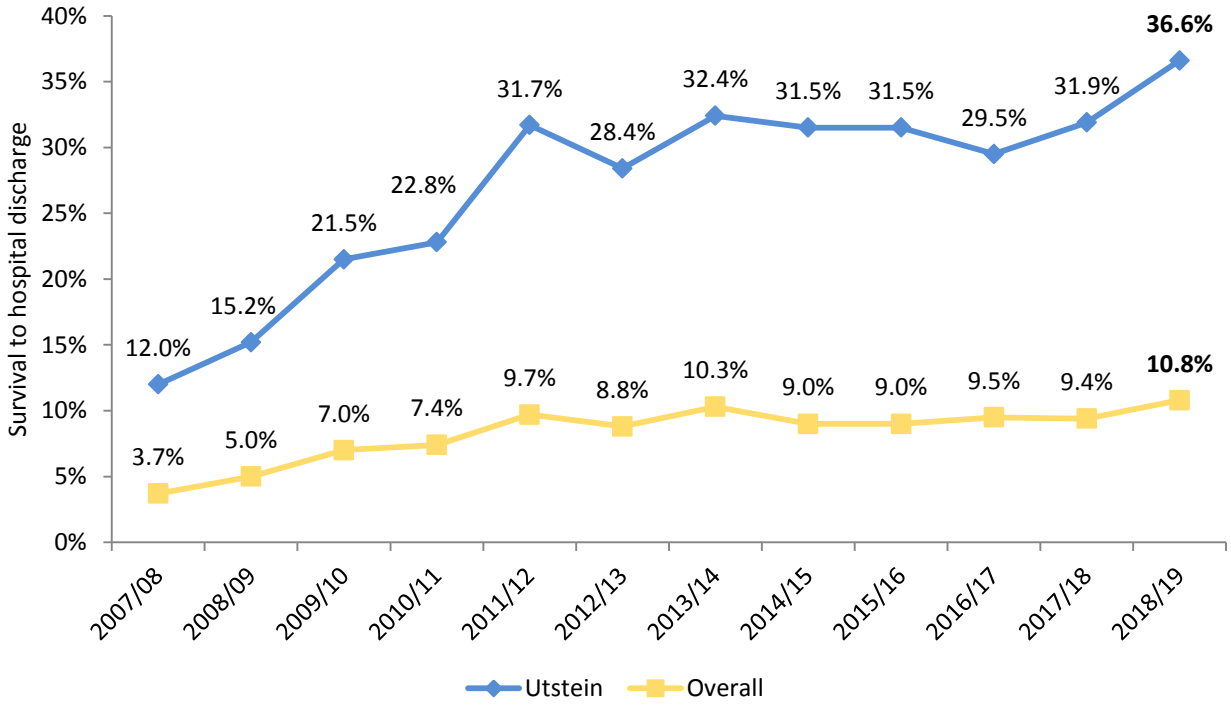

Figure 9: Survival to hospital discharge per year for all patients where resuscitation was attempted

7 Outcomes for patients conveyed to a Heart Attack Centre (HAC)

Cardiac arrest patients who have a ST-elevation Myocardial Infarction (STEMI), as identified by ambulance clinicians using a 12 Lead ECG, are conveyed to a HAC as part of a specialist pathway. The figure below shows the outcomes for this specific group of patients.

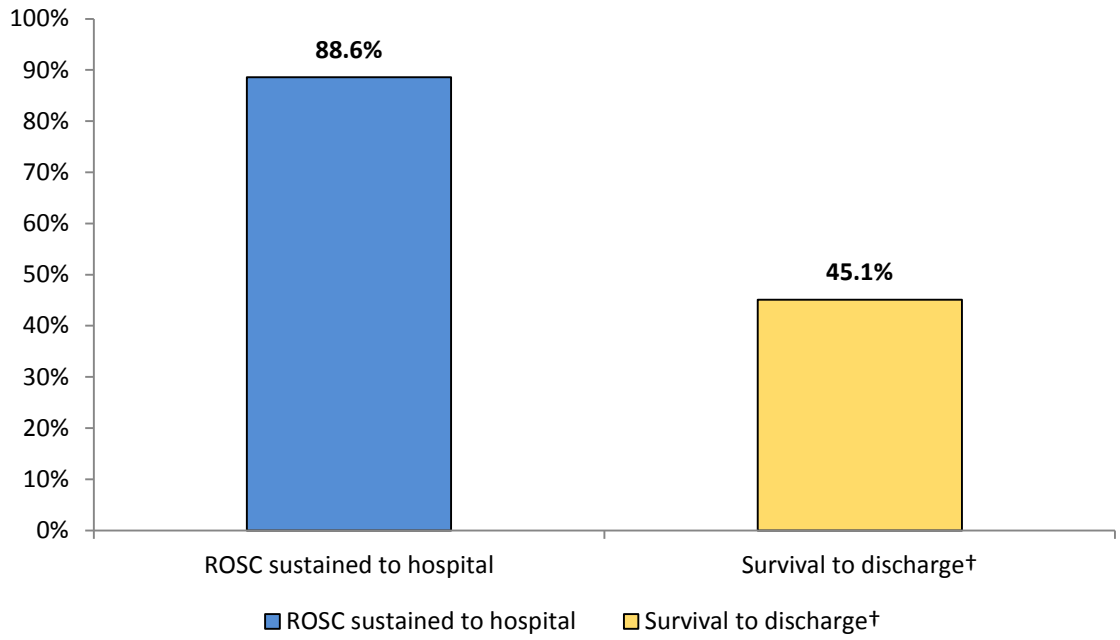

Figure 10: ROSC sustained to hospital and survival to discharge for patients conveyed to a HAC

† Denominator excludes patients with unknown survival outcomes (n=19).

- **387** patients with a suspected STEMI were conveyed to a HAC.
- **88.6%** (n=343/387) had ROSC sustained to hospital.
- As in previous years, the **majority** of these patients had an initial rhythm of **VF/VT** (72.1%, n=279) whilst asystole and PEA accounted for 10.9% (n=42) and 16.5% (n=64) respectively. Two patients (0.5%) did not have an initial rhythm documented.
- **Survival** to hospital discharge for patients within this specialist pathway remains higher than other group at **45.1%** (n=166/368).
- A breakdown of survival and initial rhythm for patients conveyed to specific London HACs can be found in Appendix 6.

8 LAS witnessed

LAS witnessed	n (%)*	ROSC sustained to hospital n (%)	Survival to discharge† n (%)
Asystole	136 (21.7)	49 (36.0)	12/131 (9.2)
PEA	342 (54.5)	113 (33.0)	25/331 (7.6)
VF/VT	138 (22.0)	90 (65.2)	73/127 (57.5)
All patients	627 (15.7)	257 (41.0)	114/597 (19.1)

Table 4: Outcome of LAS witnessed arrests

** Not documented in 11 (1.8%) cases.*

† Denominator excludes patients with unknown survival outcomes (n=30).

- LAS clinicians witnessed **627** patients suffer a cardiac arrest.
- **ROSC** sustained to hospital for this group showed a **negligible decrease** of 0.1% whereas **survival** to discharge showed an **increase** of 1.0% from 2017/18.
- More patients presented with an initial shockable rhythm (increase of 2.2% in VF/VT from 19.8% in 2017/18).

9 Advanced Paramedic Practitioners (APPs)

Advanced Paramedic Practitioners (APPs) manage resuscitation efforts and provide enhanced care to patients. APPs are dispatched to cardiac arrests either automatically or following a comprehensive triage by an APP based in the Emergency Operations Centre (EOC), who ensures that the APPs attend those who are most likely to benefit from advanced skills.

APP patient outcomes	n (%)	Change^
ROSC sustained to hospital	684/1,584 (43.2)	↑3.5%
Survival to discharge†	213/1,530 (13.9)	↑0.8%

Table 5: APP skills and patient outcomes

† Denominator excludes patients with unknown survival outcomes (n=54).

^ Increase or decrease in percentage from 2017/18.

- In **1,584** cases, an APP was present and assumed primacy of care for the patient.
- Both **ROSC** sustained to hospital and **survival** have **increased** since 2017/18 to 43.2% and 13.9% (an increase of 3.5% and 0.8% respectively).
- For patients where an APP was present, ROSC and survival to discharge has remained higher than the overall LAS figures. The rate of VF/VT in these cases was 31.7%, which is 9.8% higher than the percentage reported for all resuscitation attempted patients.

10 Conclusion

This year, we have seen a continued improvement in ROSC sustained to hospital and survival to discharge for all patients, achieving the highest rates to date. Overall ROSC sustained to hospital rates increased by 3.2% to 35.7% (up from 32.5% in 2017/18), with the Utstein ROSC sustained to hospital rate showing the largest increase of 6% to 62.6% (from 56.6% in 2017/18). Overall survival increased by 1.4% to 10.8% (from 9.4% in 2017/18) whilst survival in the Utstein comparator group rose by 4.7% to 36.6% (from 31.9% in 2017/18).

The improvements in both ROSC and survival, particularly for the Utstein sub-group, may be partly explained by increases in the numbers of patients presenting with factors that are favourable for survival. For example, we have seen an increase in the proportion of patients presenting with a presumed cardiac aetiology (78.9% vs. 76.1% in 2017/18), an increase in bystander witnessed arrests (50.2% vs. 49.8% in 2017/18), and more patients with an initial rhythm of VF/VT (for whom early defibrillation can be advantageous) or PEA (where consideration of reversible causes is beneficial). In addition, nearly two thirds of all patients (64.1%) received bystander CPR, which is a higher proportion than in any year except 2017/18 (65.3%). Four more patients received a shock from a PAD this year and overall usage remains low. However, when a PAD was used, the survival rate was over 50%. This year we have also seen fewer resuscitation attempts (39.4% vs 41.2% in 2017-18) potentially highlighting a reduction in futile resuscitations.

The increases in some of the beneficial factors that we describe will likely have been influenced by the many quality improvement and service development initiatives that that the LAS undertook during 2018-19, as outlined below.

11 Quality Improvement Activity

The LAS's five-year clinical strategy (2016-2021) sets out plans to improve outcomes from out-of-hospital cardiac arrest. In line with this, during 2018/19 the LAS has:

- Been involved in ground-breaking cardiac arrest research. For example, we continued to recruit patients into the ARREST trial[4] (a randomised controlled trial aiming to determine the best post-resuscitation care pathway for patients without ST-segment elevation on their post-ROSC ECG); worked to set up the Sub-30 pilot study which will, during 2019-20, investigate the feasibility of implementing a pre-hospital advanced cardiac arrest team to establish ECMO in out-of-hospital cardiac arrest; worked with collaborators to publish, in the New England Journal of Medicine, the results of the PARAMEDIC2 trial[5] (which investigated the role of adrenaline on outcomes from cardiac arrest), and published additional cardiac-related papers in other peer-reviewed journals[6-10].
- Continued to contribute data to the UK's national out-of-hospital cardiac arrest registry.
- Developed a paediatric resuscitation checklist, building on the success of our adult cardiac arrest checklist, to support staff decision making and enable them to optimise the care they provide when treating children in cardiac arrest.

- Worked with London Coroners and paediatric leads across London to revise our guidance for the management of deceased children to ensure that we provide the best possible care to bereaved families.
- Continued to provide all front line staff with simulation-based resuscitation training as part of the Core Skills Refresher (CSR) and provided opportunities for 1,000 clinicians to receive comprehensive feedback on their CPR skills by attending 'pop up CPR' sessions.
- With help from Macmillan Cancer Support, we improved access to Coordinate My Care (CMC) allowing our clinicians to access palliative care records at the patient's side.
- Established an End of Life Care team within the service which, along with CMC, will improve staff confidence and improve the experience for patients, who are at, or nearing, the end of their lives, and will reduce the number of inappropriate resuscitation attempts.
- Downloaded 17% of defibrillator files following resuscitation attempts (an increase of 3% from 2017-18) allowing local managers and APPs to provide immediate post event feedback to clinicians, maximising their opportunities to learn and improve.
- Increased the number of Advanced Paramedic Practitioners (Critical Care) who provide advanced care for our most seriously ill and injured patients, including people who have had cardiac arrests or been involved in major trauma. Six new APPs were recruited in 2018/19 meaning there were 34 operational APPs pan-London at the end of the year.
- Continued to use defibrillators in AED mode when our clinicians arrive at the patient's side to ensure patients who present in a shockable rhythm receive the earliest possible defibrillation attempt.
- In April 2018 we began reporting quarterly to NHS England on a new post-resuscitation care bundle for adult cardiac arrest patients where ROSC is achieved on-scene. This post-resuscitation measure examines the delivery of a range of assessments and treatments for non-traumatic cardiac arrests, including: 12 lead ECG, blood pressure, blood glucose, end-tidal CO2, oxygen and IV fluids. By being benchmarking against other ambulance services in England, and sharing our performance on this care bundle with local clinical managers, we aim to maximize the care we provide to this group of patients.
- Introduced a process to flag to local sector and clinical managers cases where clinician feedback may be required where either the full care bundle is not provided, or there is a question around a clinical decision.
- Continued to issue letters to call handlers and clinicians involved in the care of cardiac arrest patients who survive to leave hospital, to let know what happened to the patient and thank them for their role in achieving a positive outcome.
- Increased the number of public access defibrillators in the community by 332, bringing the total across London to 5,304 and provided training in CPR and basic life support to 2,168 members of the public in an effort to maximise the number of patients who receive CPR from a bystander prior to the arrival of our clinicians.
- Continued to work with the Metropolitan Police (through our co-responding initiative) and the GoodSAM smartphone app, increasing the likelihood of a trained responder attending a cardiac arrest with a defibrillator.

12 Looking Forward

Going forward, we will continue to work to improve outcomes from out-of-hospital cardiac arrest by exploring further opportunities to be involved in research in this area and continuing to review the care we provide in order to identify further areas for improvement. In 2019/20, we will complete a second thematic review into cases of missed VF and, to reduce both the likelihood of this happening and reduce the time to first shock, all of our clinicians will use defibrillators in AED mode. We will also aim to download at least 30% of defibrillator files and will look to invest in new technology to increase this further, allowing us to provide our clinicians with valuable feedback on the care they provide. In order to increase the number of patients who receive early defibrillation, we will increase the number of public access defibrillators in the community (targeting areas of low coverage), continue to train members of the public to deliver bystander CPR, and continue to work with GoodSam and our volunteer responders.

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Acknowledgments

The authors wish to acknowledge and thank Joanne Nevett for her clinical advice and guidance. The authors also wish to thank the many contacts at London hospitals for their continued support.

Glossary of abbreviations and terms

Advanced Life Support – Includes skills such as advanced airway management, manual defibrillation, cannulation and drug administration.

Basic Life Support – Includes skills such as CPR, manual airway positioning and AED use.

Bystander – A lay person or non-Emergency Medical Service personnel.

Call Connect – The time the 999 call is connected to the ambulance service.

Chief Complaint – The primary medical reason that the caller has called 999 as defined by the call triage system.

Defibrillators – The LAS use portable defibrillators to help diagnose the heart's rhythm and deliver a pre-set charged shock of 360J.

Electrocardiogram (ECG) – The LAS use 12-lead ECGs to diagnose STEMIs.

Emergency Medical Dispatchers (EMDs) – Staff based in the LAS Emergency Operations Centre that answer 999 calls and dispatch resources to patients.

Heart Attack Centre (HAC) – Specialist centres in London hospitals to which patients suffering a STEMI are taken directly for angiography and primary Percutaneous Coronary Intervention (pPCI).

Initial rhythm – The rhythm that the heart is in on initial presentation to LAS staff.

Mobile Data Terminal (MDT) – The device used by clinical staff to receive incoming call information and navigate to the location.

Paramedic – A majority of clinical staff are paramedics and are able to perform advanced airway management, cannulation and administration of drugs to cardiac arrest patients.

Patient Report Form (PRF) – The document used by the LAS to record all aspects of patient care and treatment.

Return of Spontaneous Circulation (ROSC) – Refers to a return of cardiac output by the heart after a period of cardiac arrest. ROSC sustained to hospital is the most widely used measure for out-of-hospital cardiac arrests and indicates the patient had ROSC at handover to hospital staff.

Survival to Discharge – The patient was successfully discharged from a hospital to a non-hospital environment (therefore excluding transfers from one hospital to another).

Utstein – Refers to the internationally recognised criteria for outcomes. The patients in this group are all witnessed having a cardiac arrest by a bystander, all present with an initially shockable rhythm of VF or pulseless VT and have a presumed cardiac aetiology.

Witnessed – Either seen or heard by a bystander or seen by LAS staff.

Appendix 1: ROSC sustained to hospital and Survival to discharge by aetiology

Aetiology	n (%)□	ROSC sustained to hospital n (%)	Survived to discharge† n (%)
Presumed cardiac	3,159 (78.9)	1,149 (36.4)	368/3,071 (12.0)
Other medical	298 (7.4)	98 (32.9)	18/289 (6.2)
Trauma	213 (5.3)	28 (13.1)	6/209 (2.9)
Asphyxial	211 (5.3)	110 (52.1)	14/200 (7.0)
Overdose	106 (2.6)	42 (39.6)	13/95 (13.7)
Drowning	15 (0.4)	1 (6.7)	0/11 (0.0)
Electrocution	2 (<0.1)	0 (0.0)	0/2 (0.0)

□ *The total percentages do not equal 100% due to rounding.*

† *Denominators exclude patients with unknown survival outcomes (n=128).*

Appendix 2: ROSC sustained to hospital and Survival to discharge by initial rhythm

LAS recorded initial rhythm*	n (%)□	ROSC sustained to hospital		Survival to discharge†	
		n (%)	Change^	n (%)	Change^
Asystole~	1,875 (46.8)	432 (23.0)	↑1.9%	31/1,846 (1.7)	↑0.4%
PEA	1,213 (30.3)	454 (37.4)	↑1.2%	71/1,172 (6.1)	↓0.4%
VF/VT	878 (21.9)	521 (59.3)	↑4.9%	302/829 (36.4)	↑3.5%

** Not documented in 38 (0.9%) cases.*

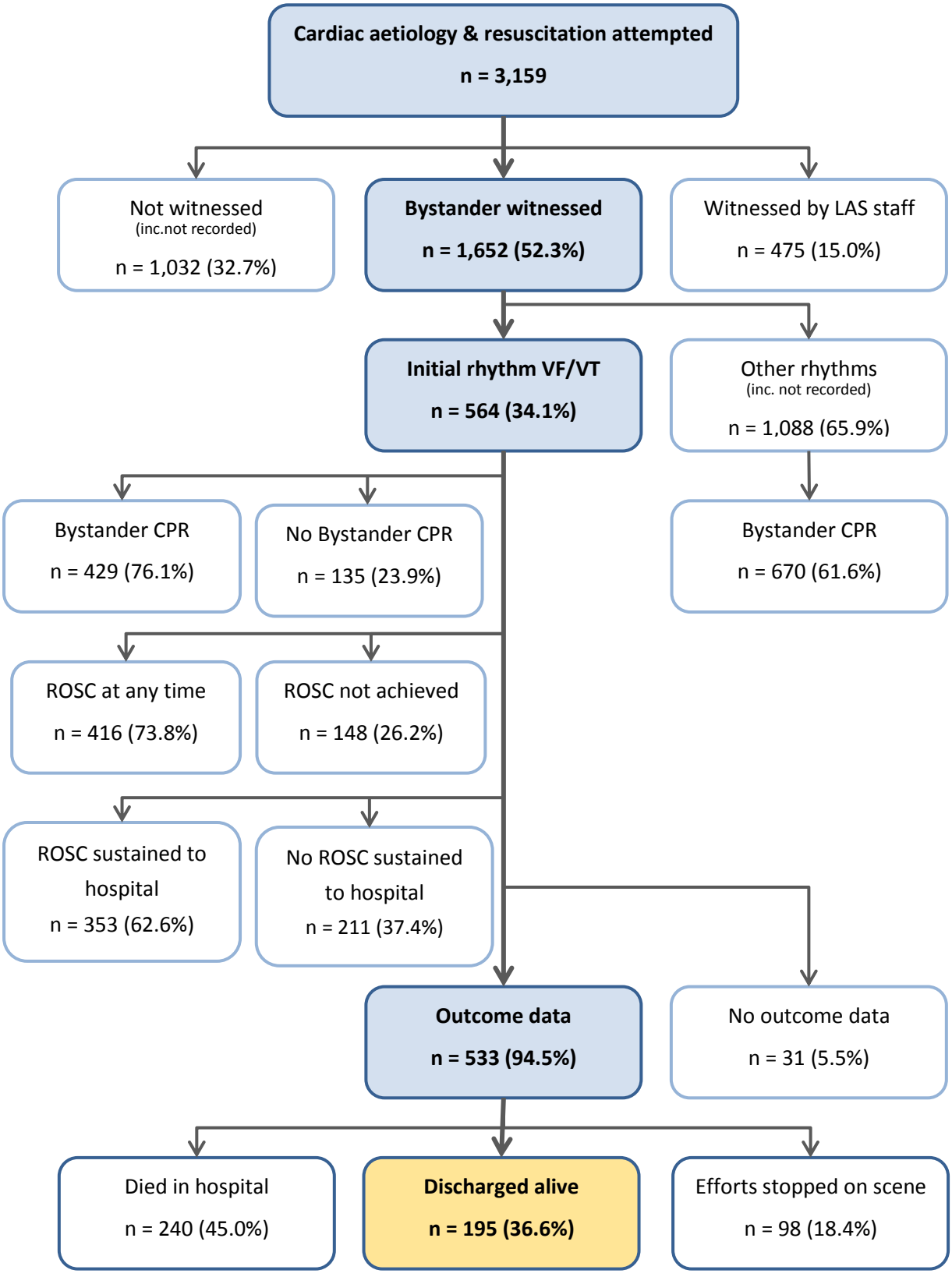
~ *Includes paediatric bradycardia (n=1).*

□ *The total percentages do not equal 100% due to rounding.*

^ *Increase or decrease in percentage from 2017/18.*

† *Denominator excludes patients with unknown survival outcomes (n=128).*

Appendix 3: Outcomes for the Utstein comparator group



Appendix 4: Patient characteristics, response times, and outcomes per Clinical Commissioning Group (CCG)

Incident CCG*	Number of patients	Age (mean years)	Male % (n)		Median response^ (mins)	Bystander CPR# % (n)		Presumed cardiac % (n)		Shockable initial rhythm % (n)		ROSC sustained to hospital % (n)		Survived to discharge+ % (n)	
Barking & Dagenham	101	62	53.5%	(54)	06:59	63.5%	(54)	84.2%	(85)	18.8%	(19)	34.7%	(35)	6.9%	(7)
Barnet	151	67	59.6%	(90)	07:45	69.7%	(92)	80.1%	(121)	17.9%	(27)	32.5%	(49)	14.1%	(21)
Bexley	117	68	62.4%	(73)	08:37	63.8%	(60)	83.8%	(98)	20.5%	(24)	30.8%	(36)	8.5%	(10)
Brent	151	63	70.2%	(106)	07:13	68.6%	(83)	82.1%	(124)	29.1%	(44)	40.4%	(61)	12.1%	(18)
Bromley	167	70	62.3%	(104)	07:21	61.5%	(80)	83.2%	(139)	24.6%	(41)	37.7%	(63)	10.7%	(17)
Camden	125	61	64.8%	(81)	06:59	69.1%	(76)	77.6%	(97)	24.0%	(30)	44.0%	(55)	16.3%	(20)
Central London	113	57	75.2%	(85)	06:35	65.0%	(67)	80.5%	(91)	32.7%	(37)	36.3%	(41)	14.9%	(15)
City & Hackney	109	61	70.6%	(77)	07:03	62.6%	(57)	78.0%	(85)	22.9%	(25)	34.9%	(38)	13.5%	(14)
Croydon	173	62	67.1%	(116)	07:50	70.5%	(105)	76.3%	(132)	20.8%	(36)	28.3%	(49)	7.6%	(13)
Ealing	143	61	69.9%	(100)	07:13	60.3%	(76)	77.6%	(111)	16.1%	(23)	35.0%	(50)	11.7%	(16)
Enfield	185	61	61.1%	(113)	07:42	68.2%	(107)	85.4%	(158)	24.9%	(46)	36.2%	(67)	13.7%	(25)
Greenwich	129	62	65.9%	(85)	07:30	64.4%	(67)	77.5%	(100)	27.1%	(35)	38.8%	(50)	9.7%	(12)
Hammersmith & Fulham	73	58	67.1%	(49)	06:24	61.7%	(37)	65.8%	(48)	23.3%	(17)	41.1%	(30)	10.0%	(7)
Haringey	133	65	59.4%	(79)	08:11	57.8%	(59)	80.5%	(107)	16.5%	(22)	36.1%	(48)	9.8%	(13)
Harrow	125	69	64.0%	(80)	07:10	52.8%	(57)	77.6%	(97)	22.4%	(28)	32.0%	(40)	7.3%	(9)
Havering	140	66	69.3%	(97)	07:49	64.8%	(83)	80.0%	(112)	24.3%	(34)	27.1%	(38)	10.5%	(14)
Hillingdon	166	65	70.5%	(117)	07:37	65.5%	(91)	78.9%	(131)	29.5%	(49)	45.2%	(75)	13.1%	(21)
Hounslow	125	64	71.2%	(89)	07:51	70.9%	(78)	80.0%	(100)	27.2%	(34)	41.6%	(52)	7.9%	(9)
Islington	100	61	62.0%	(62)	08:49	58.2%	(46)	69.0%	(69)	20.0%	(20)	39.0%	(39)	20.6%	(20)
Kingston	75	65	62.7%	(47)	06:37	64.5%	(40)	80.0%	(60)	26.7%	(20)	38.7%	(29)	15.1%	(11)
Lambeth	138	61	68.8%	(95)	07:18	66.4%	(81)	79.7%	(110)	16.7%	(23)	27.5%	(38)	8.4%	(11)
Lewisham	124	64	65.3%	(81)	07:57	58.6%	(58)	79.8%	(99)	20.2%	(25)	37.9%	(47)	10.6%	(13)
Merton	82	69	62.2%	(51)	07:02	44.8%	(30)	74.4%	(61)	17.1%	(14)	40.2%	(33)	12.2%	(10)
Newham	137	58	65.0%	(89)	07:12	64.9%	(74)	75.9%	(104)	19.0%	(26)	29.9%	(41)	6.6%	(9)
Redbridge	139	63	58.3%	(81)	07:20	61.5%	(72)	77.7%	(108)	18.0%	(25)	40.3%	(56)	11.8%	(16)
Richmond	84	65	69.0%	(58)	07:56	62.9%	(39)	73.8%	(62)	16.7%	(14)	32.1%	(27)	10.0%	(8)
Southwark	139	60	58.3%	(81)	07:33	66.1%	(80)	72.7%	(101)	18.7%	(26)	38.1%	(53)	5.7%	(7)
Sutton	95	67	56.8%	(54)	07:46	57.9%	(44)	76.8%	(73)	18.9%	(18)	32.6%	(31)	12.1%	(11)
Tower Hamlets	107	61	63.6%	(68)	07:33	58.7%	(54)	79.4%	(85)	19.6%	(21)	34.6%	(37)	7.5%	(8)
Waltham Forest	131	60	65.6%	(86)	07:20	70.3%	(83)	80.2%	(105)	21.4%	(28)	31.3%	(41)	8.4%	(11)
Wandsworth	117	64	67.5%	(79)	07:19	69.2%	(72)	84.6%	(99)	22.2%	(26)	30.8%	(36)	9.1%	(10)
West London	98	63	67.3%	(66)	07:06	65.9%	(56)	78.6%	(77)	19.4%	(19)	42.9%	(42)	12.8%	(12)

** Incidents in non-London CCGs (n=12).*

 # Figures exclude arrests witnessed by LAS staff.

^Overall response times are measured from the time the call was connected by the operator.

+ Denominators exclude patients with unknown survival outcomes.

Appendix 5: Patients with ROSC sustained to hospital who survived to discharge

Hospital name	2016/2017				2017/2018				2018/19			
	Number of patients conveyed	Sustained ROSC to hospital	Survival to discharge		Number of patients conveyed	Sustained ROSC to hospital	Survival to discharge		Number of patients conveyed*	Sustained ROSC to hospital	Survival to discharge+	
Barnet	41	17	12.5%	(2/16)	50	23	26.1%	(6/23)	30	17	20.0%	(3/15)
St Barts	133	119	57.8%	(67/116)	125	97	55.8%	(53/95)	132	117	50.0%	(58/116)
Charing Cross	31	14	21.4%	(3/14)	34	16	9.1%	(1/11)	37	25	20.0%	(5/25)
Chelsea & Westminster	19	10	25.0%	(2/8)	33	21	27.8%	(5/18)	24	17	14.3%	(2/14)
Croydon	87	40	15.8%	(6/38)	69	34	14.7%	(5/34)	70	35	29.4%	(10/34)
Darent Valley	15	5	20.0%	(1/5)	11	4	0%	(0/4)	6	2	50.0%	(1/2)
Ealing	44	16	18.8%	(3/16)	56	30	16.7%	(5/30)	43	22	18.2%	(4/22)
Hammersmith	82	73	52.1%	(37/71)	88	70	47.0%	(31/66)	88	80	51.3%	(40/78)
Harefield	40	32	46.9%	(15/32)	61	48	54.2%	(26/48)	51	42	45.0%	(18/40)
Hillingdon	63	23	27.3%	(6/22)	68	38	15.8%	(6/38)	74	41	13.2%	(5/38)
Homerton	39	19	26.3%	(5/19)	44	21	4.8%	(1/21)	25	12	0%	(0/9)
King's College	189	118	41.7%	(45/108)	189	138	36.5%	(46/126)	176	126	35.2%	(38/108)
King George	47	19	0.0%	(0/17)	57	21	4.8%	(1/21)	49	24	16.7%	(4/24)
Kingston	56	25	8.3%	(2/24)	64	31	16.1%	(5/31)	47	28	23.1%	(6/26)
Newham	70	30	7.1%	(2/28)	80	31	10.3%	(3/29)	70	30	20.7%	(6/29)
North Middlesex	89	33	24.2%	(8/33)	107	52	17.3%	(9/52)	94	55	27.8%	(15/54)
Northwick Park	98	52	26.9%	(14/52)	110	55	9.6%	(5/52)	95	48	15.2%	(7/46)
Princess Royal	60	32	12.5%	(4/32)	59	33	3.1%	(1/32)	63	29	13.8%	(4/29)
Queen Elizabeth	101	44	18.6%	(8/43)	107	45	15.9%	(7/44)	91	38	13.2%	(5/38)
Queen's Romford	107	55	8.0%	(4/50)	119	56	9.6%	(5/52)	95	45	20.5%	(8/39)
Royal Free	132	86	47.7%	(41/86)	150	107	42.5%	(45/106)	156	121	42.1%	(51/121)
Royal London	78	38	22.6%	(7/31)	86	44	18.4%	(7/38)	77	48	19.2%	(9/47)
St George's	168	122	42.9%	(48/112)	184	133	36.4%	(47/129)	141	104	43.8%	(42/96)
St Helier	53	24	17.4%	(4/23)	44	21	10.0%	(2/20)	41	22	4.8%	(1/21)
St Mary's	76	39	23.7%	(9/38)	70	42	25.7%	(9/35)	68	43	23.1%	(9/39)
St Thomas'	129	83	38.5%	(30/78)	112	71	47.8%	(32/67)	113	85	36.8%	(21/57)
University College Hospital	33	20	40.0%	(8/20)	34	15	26.7%	(4/15)	32	18	41.2%	(7/17)
University Hospital Lewisham	51	26	11.5%	(3/26)	58	30	17.2%	(5/29)	65	40	15.0%	(6/40)
West Middlesex	66	25	0.0%	(0/24)	78	38	9.4%	(3/32)	74	39	9.7%	(3/31)
Whipps Cross	89	38	16.2%	(6/37)	76	37	16.7%	(5/30)	70	34	11.8%	(4/34)
Whittington	35	15	7.1%	(1/14)	32	16	18.8%	(3/16)	47	26	30.8%	(8/26)

* Patients *conveyed to non- London hospitals (n=17) are excluded from the table.*

+ Denominators exclude patients with unknown survival outcomes.

Appendix 6: Rhythm and survival per Heart Attack Centre for cardiac arrest patients with a STEMI

Heart Attack Centre	Number of patients conveyed	Initial rhythm□			Sustained ROSC to hospital	Survival to discharge+
		Asystole	VF/VT	PEA		
St Barts	91	15.4% (14)	68.1% (62)	16.5% (15)	83	46.7% (42/90)
Essex Cardiothoracic Centre	6	16.7% (1)	83.3% (5)	0% (0)	5	50.0% (3/6)
Hammersmith	57	12.3% (7)	66.7% (38)	21.1% (12)	53	40.0% (22/55)
Harefield◆	32	6.3% (2)	75.0% (24)	15.6% (5)	26	41.4% (12/29)
King's College	58	3.4% (2)	75.9% (44)	20.7% (12)	52	47.9% (23/48)
Royal Free◆	71	14.1% (10)	71.8% (51)	12.7% (9)	61	52.1% (37/71)
St George's	47	10.6% (5)	68.1% (32)	21.3% (10)	38	40.9% (18/44)
St Peter's Chertsey	3	0% (0)	100.0% (3)	0% (0)	3	0% (0/3)
St Thomas'	22	4.5% (1)	90.9% (20)	4.5% (1)	22	61.9% (13/21)

◆ *One patient conveyed to Harefield and one patient conveyed to the Royal Free did not have their initial arrest rhythm documented.*

+ Denominators exclude patients with unknown survival outcomes.

□ *The total percentages do not equal 100% due to rounding.*

Appendix 7: Cardiac arrest patients under 35 years old

	Under 1	1-8	9-18	19-35
Number of patients:	54	40	56	282
Gender:				
Male	51.9% (28)	52.5% (21)	71.4% (40)	73.0% (206)
Female	48.1% (26)	47.5% (19)	28.6% (16)	27.0% (76)
Arrest location:				
Private	94.4% (51)	90.0% (36)	57.1% (32)	48.2% (136)
Public	5.6% (3)	10.0% (4)	42.9% (24)	51.8% (146)
Witnessed:				
Bystander	33.3% (18)	45.0% (18)	41.1% (23)	40.8% (115)
LAS staff	9.3% (5)	10.0% (4)	8.9% (5)	14.9% (42)
Unwitnessed	57.4% (31)	45.0% (18)	50.0% (28)	44.3% (125)
Bystander CPR[#]:				
Yes	65.3% (32/49)	66.7% (24/36)	70.6% (36/51)	69.2% (166/240)
No	34.7% (17/49)	33.3% (12/36)	29.4% (15/51)	30.8% (74/240)
Aetiology[□]:				
Presumed Cardiac	74.1% (40)	67.5% (27)	26.8% (15)	41.5% (117)
Other Medical	20.4% (11)	15.0% (6)	14.3% (8)	5.3% (15)
Trauma	1.9% (1)	0.0% (0)	32.1% (18)	27.7% (78)
Asphyxial/Respiratory	1.9% (1)	15.0% (6)	21.4% (12)	12.4% (35)
Overdose	0.0% (0)	0.0% (0)	5.4% (3)	11.0% (31)
Drowning/Submersion	1.9% (1)	0.0% (0)	0.0% (0)	2.1% (6)
Electrocution	0.0% (0)	2.5% (1)	0.0% (0)	0.0% (0)
Initial Rhythm:				
Asystole~	77.8% (42)	67.5% (27)	58.9% (33)	51.4% (145)
PEA	14.8% (8)	22.5% (9)	33.9% (19)	28.4% (80)
VF/Pulseless VT	0% (0)	7.5% (3)	5.4% (3)	17.7% (50)
Not Documented	7.4% (4)	2.5% (1)	1.8% (1)	2.5% (7)
ROSC sustained to hospital:				
Yes	25.9% (14)	32.5% (13)	12.5% (7)	35.5% (100)
No	74.1% (40)	67.5% (27)	87.5% (49)	64.5% (182)
Survived to discharge[+]:				
Yes	12.2% (6)	10.8% (4)	5.6% (3)	13.7% (37)
No	87.8% (43)	89.2% (33)	94.4% (51)	86.3% (234)

[#] *Figures exclude arrests witnessed by LAS staff.*

[□] *The total percentages for Under 1 aetiology do not equal 100% due to rounding.*

~ Includes paediatric bradycardia (n=1).

+ Denominators exclude patients with unknown survival outcomes.

London Ambulance Service
NHS Trust

ST Elevation Myocardial Infarction Annual Report 2018/19

December 2019

Produced by:

Clinical Audit and Research Unit,
London Ambulance Service NHS Trust,
8-20 Pocock Street,
London,
SE1 0BW.

✉ CARU.Enquiries@lond-amb.nhs.uk

Contents

London Ambulance Service NHS Trust

STEMI Overview | 2018-19

3,449
Total number of suspected STEMIs

25%
70 years*

75%
59 years*

* Mean average

47%
Anterior STEMI on ECG

999 call to scene
19 minutes

On scene
39 minutes

Journey time
18 minutes

999 call to hospital
77 minutes

Care Bundle

- ✓ Aspirin
- ✓ GTN
- ✓ 2 Pain Assessments
- ✓ Analgesia

78%
Received full bundle or had valid exceptions

78%
Confirmed as STEMI at hospital

89%
Confirmed STEMIs had pPCI

128 minutes
999 call to balloon inflation time

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1 Introduction

Between April 1st 2018 and March 31st 2019, 3,449 patients with a suspected ST-Elevation Myocardial Infarction (STEMI) were attended by London Ambulance Service (LAS) crews.

When a STEMI is suspected, LAS clinicians will perform a number of assessments including a 12 lead electrocardiogram (ECG) to confirm diagnosis. The STEMI care bundle outlines the treatment these patients should receive (including aspirin, GTN and analgesia). In line with the LAS STEMI pathway, patients will be conveyed directly to a specialist Heart Attack Centre (HAC) where angiography and reperfusion procedures can be performed rapidly. Clinicians are encouraged to keep on scene times for these patients as short as possible to minimise the time to definitive treatment.

This report presents data relating to the pre-hospital clinical care provided by the LAS, details of the interventions performed at hospital and the patients' outcomes. Data was sourced from the LAS Acute Coronary Syndrome (ACS) registry, which is populated with information extracted from the Patient Report Forms (PRFs) that are completed by the attending clinicians, 12 lead ECG readings and vehicle Mobile Data Terminals (MDTs). Hospital information is collected chiefly from the Myocardial Ischaemia National Audit Project (MINAP) database, with additional data provided directly by hospitals when required.

2 Findings

2.1 Patient demographics

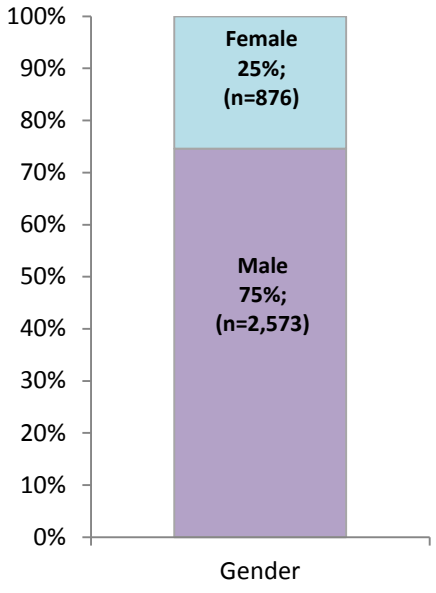


Figure 1: Gender distribution

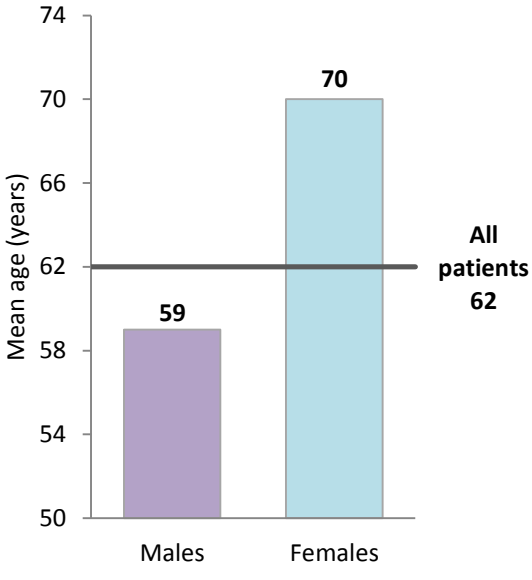


Figure 2: Age of STEMI patients by gender

- The demographics reported are similar to previous years:
  - three-quarters of patients were male.
  - mean patient age was 62 years, with males 11 years younger on average than females.

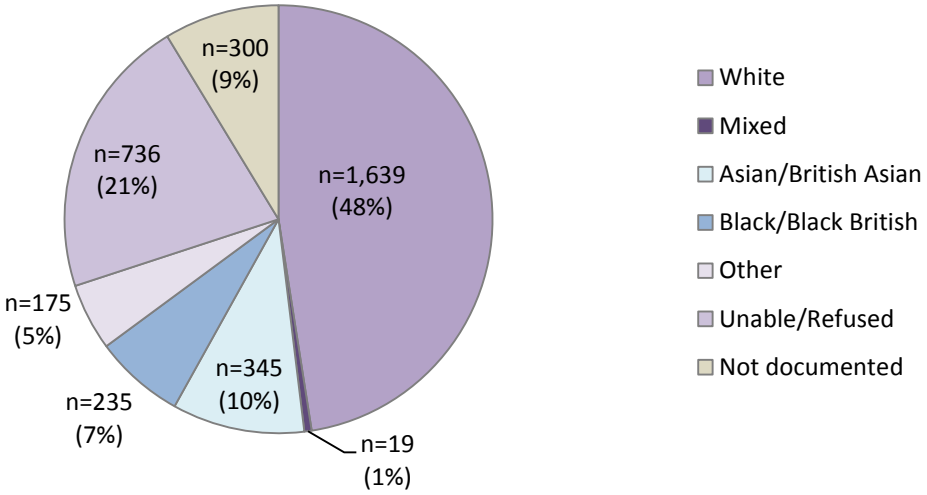


Figure 3: Breakdown of patient ethnic origin

- Just under half of all patients were of a white ethnic origin.
- A fifth either refused or were unable to provide information regarding their ethnic origin.

2.2 Call information

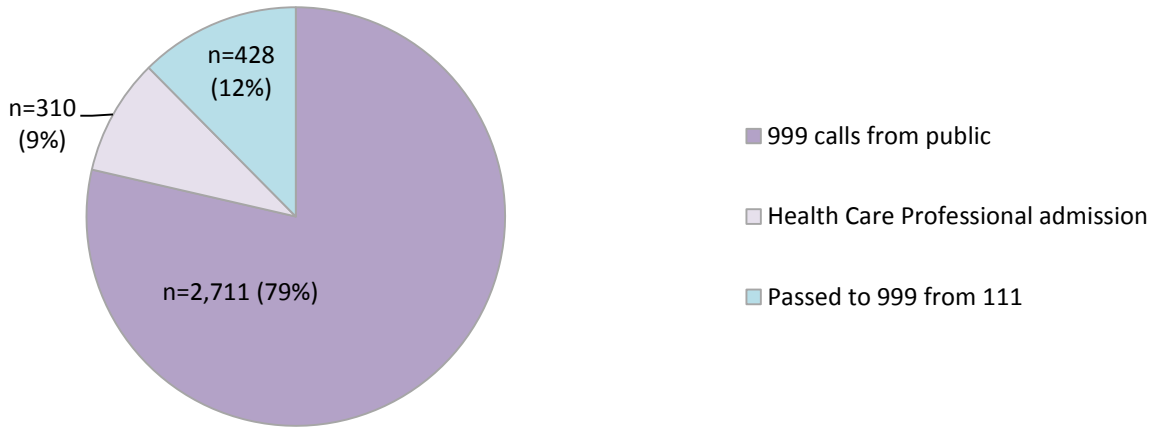


Figure 4: Origin of calls to the LAS

- 79% (n=2,711) of calls were from members of the public who dialled 999 directly; this is a 4% decrease from last year.

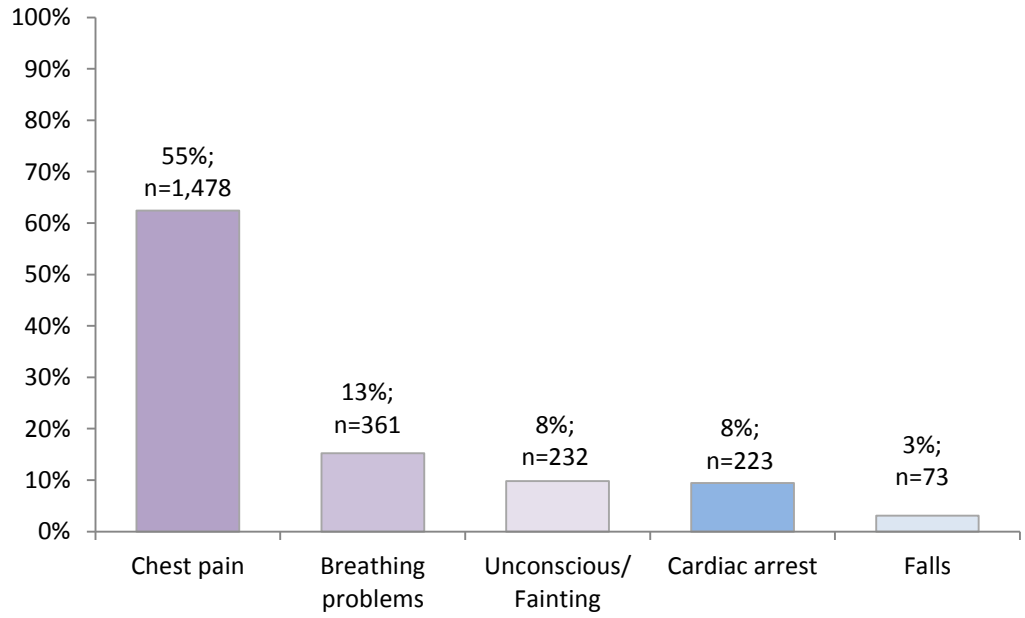


Figure 5: Top 5 chief complaints for 999 calls from members of the public

- Where a 999 call originated from a member of the public, the information provided enabled chest pain to be identified as the chief complaint for 55% of patients.

2.3 Infarct details

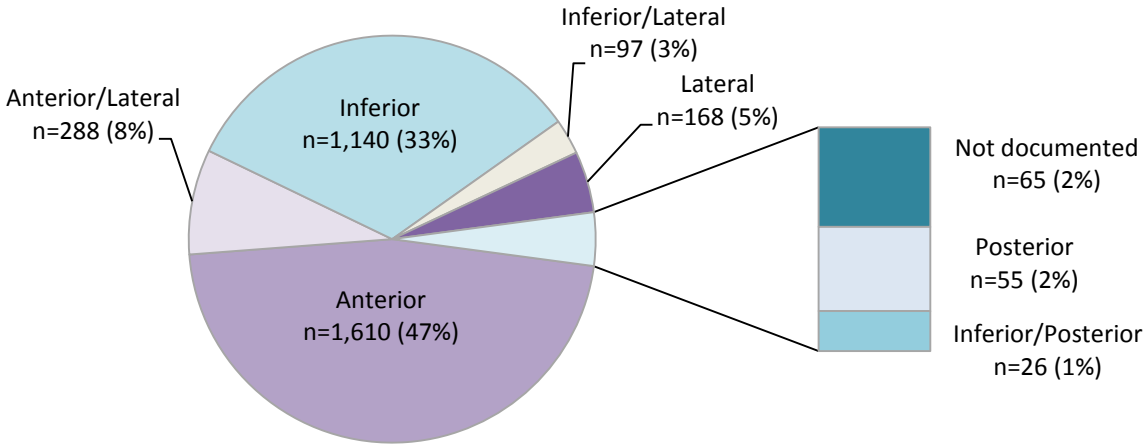


Figure 6: Location of infarct

- As with previous years, the majority (47%) of infarcts were located in the anterior region of the heart, followed by the inferior region (33%).
- In 2% of cases, the infarct location was not clearly documented on the PRF.

2.4 Response information

Calls received via 999 are triaged into one of 5 Call Categories, depending on the severity of the patient's condition. Each category has an associated target response time (defined by NHS England's Ambulance Response Programme -ARP)[1] which is designed to ensure patients receive the most clinically appropriate response. STEMI patients require timely intervention at a specialist centre and as such require prompt dispatch of a vehicle capable of conveying them to hospital. The majority of patients calling with chest pain suggestive of a STEMI will receive a Category 2 response which will trigger the rapid dispatch of a conveying vehicle.

Response times for clock start and stop times are presented below.

Category	Response standard (minutes)		Definitions
	Mean	90th centile	
Category 1 (Life threatening)	7	15	Clock start The earliest time that: • the call is assigned a chief complaint; or • the first resource is dispatched; or • 30 seconds from the call connecting. Clock stop The arrival of the first LAS resource (whether a solo responder or an ambulance).
Category 2 (Emergency)	18	40	Clock start The earliest time that: • the call is assigned a chief complaint; or • the first resource is dispatched; or • 240 seconds from the call connecting Clock stop The arrival of the first LAS vehicle able to transport the patient to hospital.
Category 3 (Urgent)	120 (90th centile)		
Category 4 (Less urgent)	180 (90th centile)		
Category 5 (Hear and Treat)			

3.4.1 Response by Category

Category	No. (%)	Response time, minutes*		
		Mean	Median	90th Centile
Category 1	509 (15%)	6	6	10
Category 2	2,735 (79%)	19	14	38
Category 3	166 (5%)	46	30	106
Category 4	33 (1%)	74	61	132
Category 5†	6 (~0%)	33	24	68
Overall	**3,449**	**19**	**13**	**40**

Table 1: Response time by Call Category

† *Call Category definitions were updated in November 2018, with Category 5 replacing Category C4H.*

** Response time is measured using ARP clock start to clock stop definitions.*

- The majority of calls (79%) were allocated a Category 2 response.
- The mean time from clock start to clock stop was 19 minutes in 2018/19. This represents a decrease of 3 minutes since the introduction of ARP.

3.4.2 First Vehicle on Scene

Category one calls will routinely have a solo responder dispatched who can arrive on scene quickly and provide lifesaving interventions whilst awaiting the arrival of an ambulance capable of conveying the patient to hospital. When a patient calls with chest pain, and there is no ambulance available to dispatch immediately, a solo responder may be dispatched so that the patient can receive timely face to face assessment and treatment can begin promptly.

First Vehicle on Scene	Call Category					Total
	C1	C2	C3	C4	C5	
Conveying Ambulance	163 (32%)	2383 (87%)	146 (88%)	26 (79%)	5 (83%)	2723 (79%)
Other Vehicle	346 (68%)	352 (13%)	20 (12%)	7 (21%)	1 (17%)	726 (21%)
Total	**509**	**2735**	**166**	**33**	**6**	**3449**

Table 2: Call category broken down by first vehicle on scene

- For the majority of calls (79%), a conveying ambulance was the first vehicle to arrive on scene.
- 726 patients did not receive an ambulance as the initial response. 346 of these (48%) were Category 1, the remaining 380 (52%) were lower priority calls.

2.5 On-scene times (minutes)

From the arrival of:	On-scene time		
	Mean	Median	90th centile
First attending vehicle (any)	39	36	59
First conveying ambulance	36	33	56

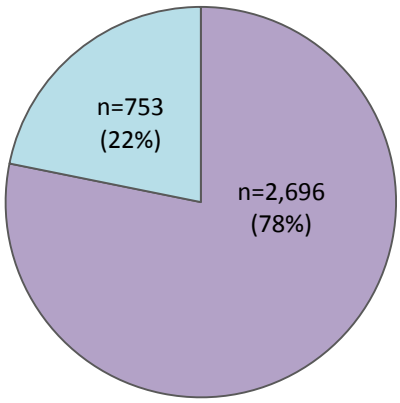
Table 3: On-scene times

- The mean time from the arrival of the first attending vehicle to the conveying ambulance leaving scene was 39 minutes this year, which is 2 minutes faster than last year.
- Mean on-scene time from the arrival of the first vehicle capable of transporting the patient to the conveying ambulance leaving the scene was 36 minutes.

2.6 STEMI patient care

2.6.1 Care bundle compliance

The STEMI care bundle describes the aspects of care that should be delivered to all patients with a suspected STEMI.



Components of full care bundle:

- Aspirin
- GTN
- Two pain assessments (pre- and post-treatment)
- Analgesia

Figure 7: Full care bundle administration

- 78% of patients received a complete care bundle or had a valid exception - a 4% increase from last year.
- Information on the provision of specific components of the care bundle is shown in sections 3.6.2 and 3.6.3.

2.6.2 Aspirin and glyceryl trinitrate (GTN)

All STEMI patients should be given aspirin and GTN (unless presenting with a valid exception to treatment) in order to benefit from the increased blood flow to the heart that these medications can provide.

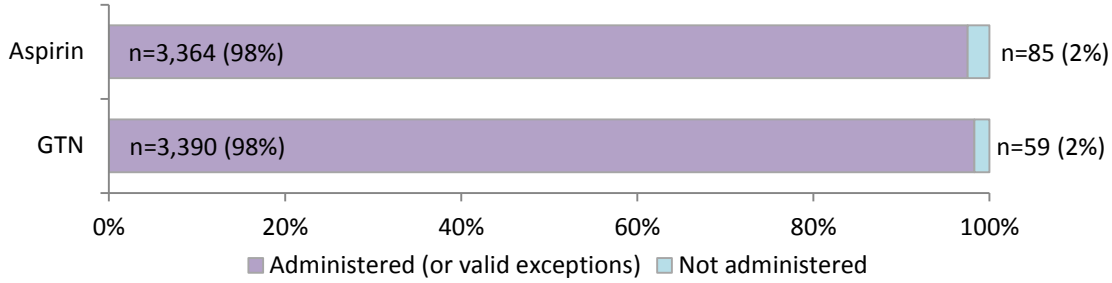


Figure 8: Aspirin and GTN administration

- 98% of all patients either received or had a valid exception to aspirin, with the same also applying to GTN.

2.6.3 Pain assessment and management

Pain assessment is a key part of patient care, ensuring the most appropriate treatment is delivered and assessing its effectiveness. Where possible, the patient will be asked to score their pain on a scale from 0 to 10 (where 10 indicates the most severe pain). However, if the patient is unable to provide a numerical score, a descriptive qualitative assessment of their pain can also be used to guide treatment decisions.

When a patient is pain free (either from the outset, or as a result of treatment with aspirin and GTN), analgesia is not required (although the fact the patient is pain free still needs to be recorded). For those patients who report that their level of pain is mild, Entonox should be offered as the most

appropriate form of analgesia. In patients with a pain score of 4 or above, morphine is the indicated treatment. However, where it is not possible to deliver morphine (e.g. due to contraindications or unsuccessful intravenous access), Entonox should still be offered in order to attempt to relieve the patient's pain. Such treatment decisions should be well documented on the PRF.

2.6.3.1 Pain assessment

- 98% of patients (n= 3,364) received both a pre- and post-treatment pain assessment (or had a valid exception).
- 2,796 patients were reported as having pain that had not been completely relieved by the administration of aspirin and GTN. These patients were therefore eligible for analgesic treatment (see below).

2.6.3.2 Analgesic drugs administered

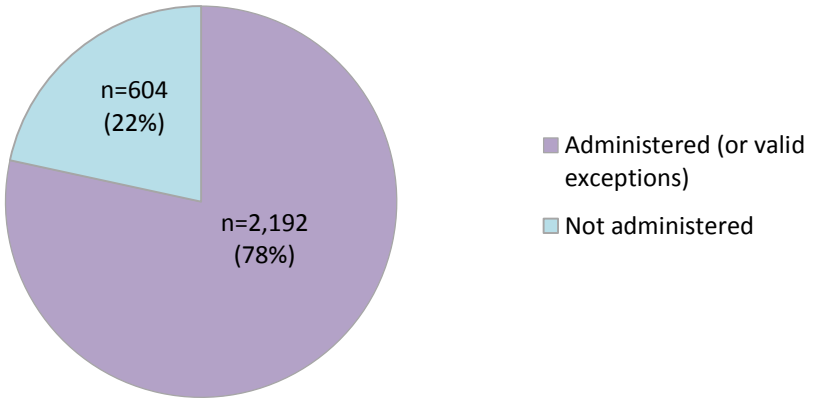


Figure 9: Administration of analgesia

- 78% (n=2,192/2,796) of patients who reported still being in pain following aspirin and GTN administration received at least one form of analgesia (or had valid exceptions to both). This is an increase of 3% from last year.

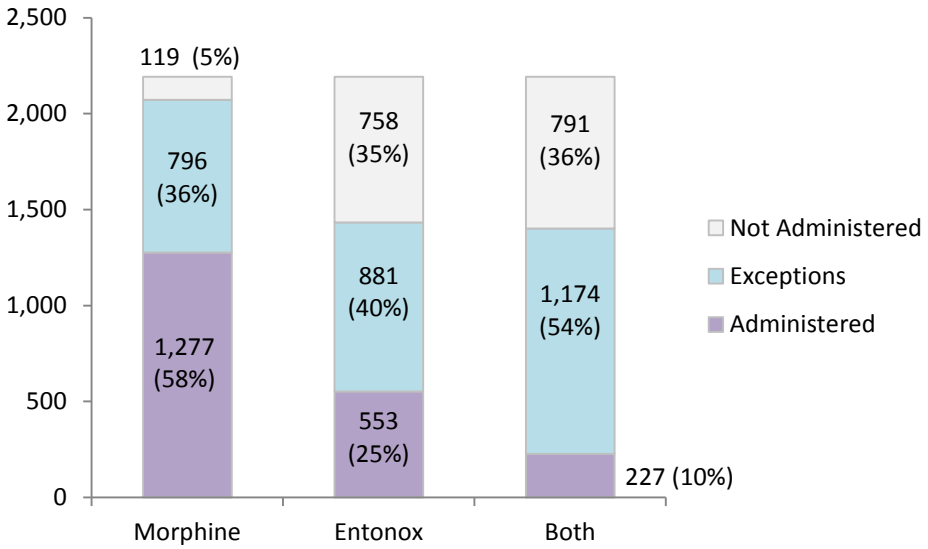


Figure 10: Type of analgesia administered

N.B. Each bar of the chart includes all 2,192 patients who received some form of analgesia.

- Of the two available analgesics, morphine remains the most frequently administered (58%, n=1,277).
- Only 10% (n=227) of patients received both drugs whilst 54% (n=1,174) had a valid exception to receiving both drugs.
- The first reported pain levels for the 604 patients who were in pain and did not receive any analgesia can be found in 2.6.3.3.

2.6.3.3 Pain level of patients not receiving analgesia

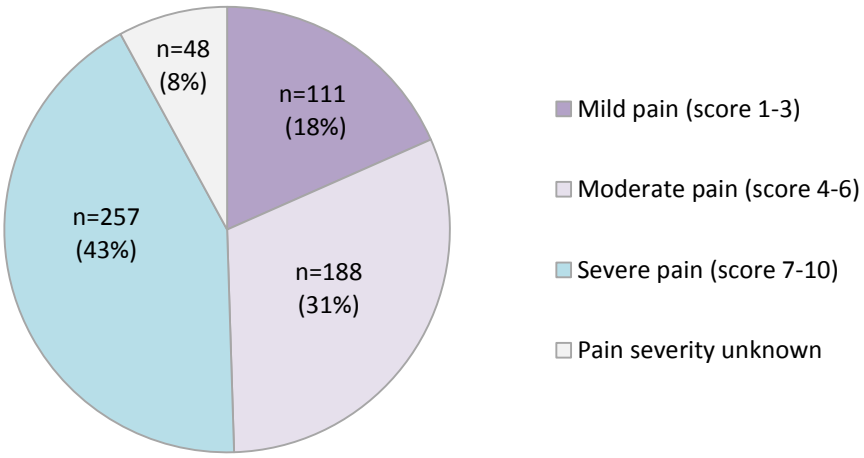


Figure 11: First reported pain level of patients who reported pain and did not receive analgesia

- 43% (n=257) of the 604 patients who reported pain post-aspirin and GTN administration and did not receive any analgesia were in severe pain.

2.7 Conveyance

Within the LAS' catchment area, there are nine specialist Heart Attack Centres (HACs) to which STEMI patients should be directly conveyed in order to receive the most rapid and effective assessment and potential surgical intervention. In certain circumstances (such as an unmanageable airway, uncontrolled seizures, or a patient refusing to go to a HAC), it may be appropriate for the patient to be transported to the nearest Emergency Department (ED).

2.7.1 Destination of STEMI patients

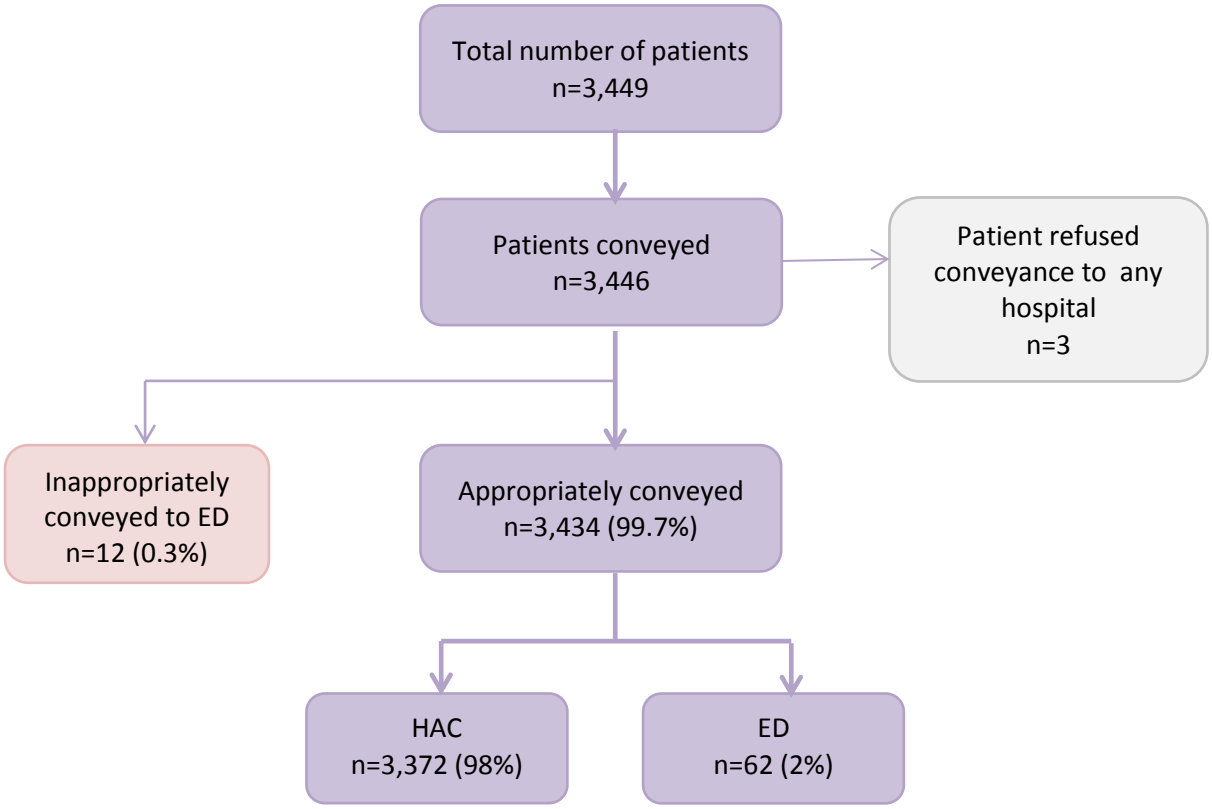


Figure 12: Patient destination

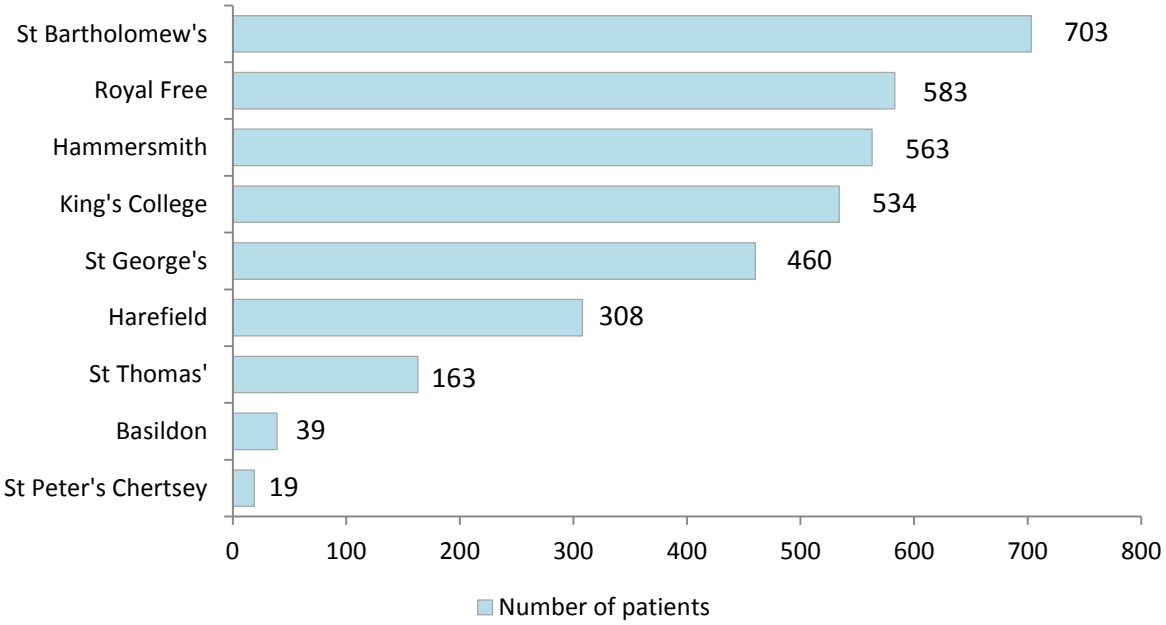


Figure 13: Number of patients conveyed to each HAC

- Consistent with recent years, nearly all patients were conveyed to an appropriate destination.
- 98% of patients were transported to a HAC.
- St Bartholomew's remains the HAC which receives the highest number of patients.
- Patient numbers for St Peter's and Basildon Hospitals are notably lower than for other HACs due to their location within in our catchment areas.

2.7.2 Journey and call to hospital times (minutes)

Destination	999 call – arrive hospital†			Leave scene – arrive hospital		
	Mean	Median	90th centile	Mean	Median	90th centile
HAC	77	71	108	18	17	30
ED	70	67	104	12	10	21

Table 4: Journey and call to hospital times

†*999 call to hospital times shown have been calculated from call connect time.*

- The mean time from 999 call to arriving at hospital increased by 2 minutes to 77 minutes.
- The mean journey time for patients conveyed directly to a HAC remained at 18 minutes.

2.8 Reperfusion and patient outcomes

Following arrival at a HAC, patients are further assessed by hospital staff and may undergo reperfusion treatment. For the majority of patients, this will involve Primary Percutaneous Coronary Intervention (pPCI) whereby a catheter is inserted to unblock the artery, a small balloon inflated and a stent placed to ensure the artery remains open. In a small number of cases, patients may receive thrombolytic drug treatment (to dissolve the blockage) or other surgical interventions.

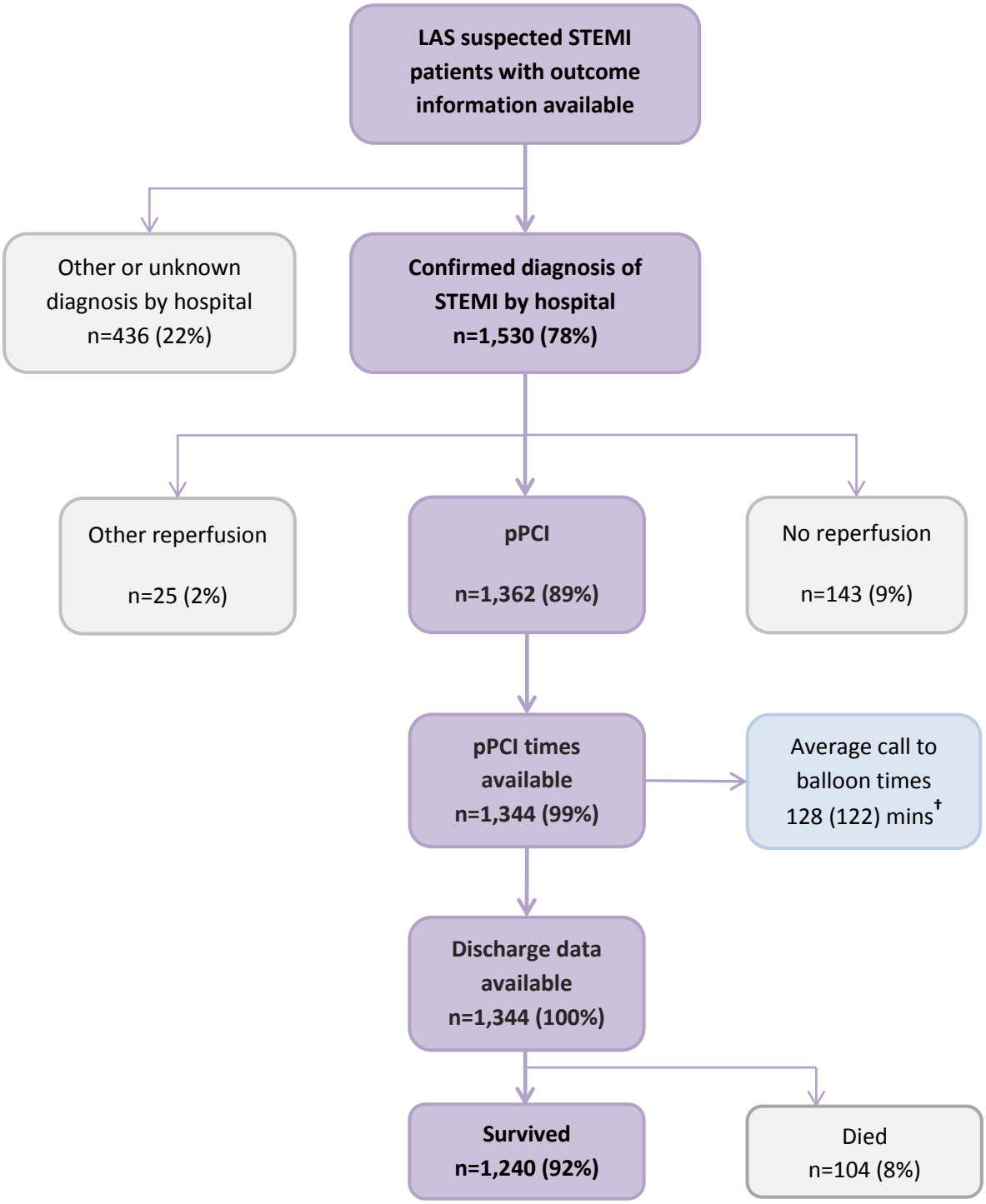


Figure 14: Outcomes for patients who received reperfusion at a HAC

† Mean (median) based on 999 call connect time.

- 78% of suspected STEMI patients conveyed to a HAC were diagnosed with a confirmed STEMI by hospital staff, which is an increase of 11% from last year, and 89% received pPCI treatment. However, 22% of patients were not confirmed as STEMI at hospital.
- The time from the 999 call to balloon insertion time was 128 minutes. This remains consistent with last year's time and sits comfortably within the national target of 150 minutes[1].
- Of patients receiving pPCI treatment, 92% were discharged from hospital alive, increasing by 1% from last year.

3 Quality Improvement activity

During 2018/19, we continued our efforts to improve the care we provide to STEMI patients, in line with our five year clinical strategy. This included:

- Updating our clinical guidance on the management of STEMI patients, in response to feedback from clinical staff, to ensure that there is clear direction on the use of GTN in the presence of Right Ventricular MI.
- Releasing an infographic poster for staff detailing the four elements of the STEMI care bundle, and the a valid exceptions for each.
- Sharing a STEMI patient case study in our quarterly Clinical Update for our clinicians, highlighting the necessary components of the STEMI care bundle.
- Introduced a process to flag to local sector and clinical managers cases where clinician feedback may be required where either the full care bundle is not provided, or there is a question around a clinical decision.
- Working with NHS England and the Myocardial Ischaemia National Audit Project (MINAP) on the development of an improved national process for sharing data which will allow us to collect more reliable and complete outcomes data for our STEMI patients.
- Running continued professional development (CPD) sessions for a range of staff groups across the trust on ECG interpretation and management of STEMI patients.

4 Summary

The LAS continues to maintain a high standard of care, with a good level of pain assessment and treatment using aspirin and GTN. We recognise that in order for care bundle provision to improve further a greater focus on delivering appropriate analgesia to patients is needed. We have continued to demonstrate excellent compliance with specialist conveyance pathways, and our outcomes data show that patients continue to receive pPCI treatment well within the national time targets.

References

1. https://www.england.nhs.uk/urgent-emergency-care/improving-ambulance-services/arp/
2. Treatment of Heart Attack National Guidance – Final Report of the National Infarct Angioplasty Project (NIAP), Crown, 2008.

Acknowledgements

CARU wishes to thank colleagues in the Medical Directorate for their ongoing support.

Glossary of abbreviations and terms

Aspirin – Aspirin thins the blood and improves its flow through the arteries.

Call Connect – The time the 999 call is connected to the ambulance service.

Call to Balloon Time – The overall time taken from the initial 999 emergency call to the point of balloon inflation in a primary Percutaneous Coronary Intervention (pPCI) procedure performed at hospital.

Cardiac Catheter Laboratory (Cath Lab) – The area within a specialist Heart Attack Centre where patients receiving reperfusion will be treated.

Care Bundle – The optimum combination of observations and treatments that ambulance crews should perform so that the patient receives the best possible care.

Clinical Commissioning Group – NHS organisations that govern the delivery of services within areas of England.

Entonox – A mix of 50% nitrous oxide and 50% oxygen (also known as “gas and air”).

First arriving vehicle – A resource dispatched to immediately life-threatening calls which can include a solo responder (such as a car, motorcycle, bicycle response) or an ambulance.

Glyceryl Tri-Nitrate (GTN) – A drug which allows blood vessels to relax and widen, thus allowing improved blood flow and reducing the workload of the heart.

Heart Attack Centre (HAC) – Specialist centres in London hospitals to which patients suffering a STEMI are taken directly for primary Percutaneous Coronary Intervention (pPCI).

Medical Priority Dispatch System (MPDS) – A medically approved system used by call handlers to triage patients based on their responses to pre-determined questions.

Mobile Data Terminal (MDT) – The device used by clinical staff to receive incoming call information and navigate to the location.

Morphine – An analgesic which can be administered (usually intravenously) by a paramedic.

Myocardial Infarction (MI) – Commonly known as a 'heart attack'. A myocardial infarction refers to a blockage of the coronary artery that limits blood flow to an area of the heart.

Myocardial Ischaemia National Audit Project (MINAP) – A national registry maintained by hospitals containing details of patients who were taken to Heart Attack Centres, reperfusion treatment performed and patient outcomes.

Numerical rating scale – A method of rating a patient's pain based on a score from zero (no pain) to 10 (the worst pain imaginable).

Pain assessment – An observation which should be taken both pre- and post-treatment to assess the patient's level of pain.

Paramedic – A type of clinical staff that are able to perform advanced skills such as cannulation to allow for the delivery of drugs intravenously.

Patient Report Form (PRF) – The document used by the LAS to record all aspects of patient care and treatment.

Primary Percutaneous Coronary Intervention (pPCI) – A surgical procedure performed at a Heart Attack Centre which seeks to unblock arteries by means of insertion of a catheter into the affected artery and inflating a small balloon to re-open it. The opened artery is then held in place with a small stent.

ST-Elevation Myocardial Infarction (STEMI) – A type of myocardial infarction. ST-Elevation refers to a particular pattern seen on a 12-Lead ECG which indicates a complete blockage in a coronary artery.

Thrombolysis – A form of reperfusion which breaks down blood clots by pharmacological means (also known as "clot busting"). It is now generally only used in a small number of patients who are not suitable for primary Percutaneous Coronary Intervention treatment and is undertaken at hospital.

Appendix 1: On-scene times and care bundle provision by Clinical Commissioning Group of incident location

Incident CCG	Mean (median) on-scene times, minutes		Complete Care Bundle delivered			
	Arrival of first vehicle	Arrival of first conveying vehicle	Yes/ Exception		No	
			n	%	n	%
Barking & Dagenham	40 (38)	39 (36)	63	79%	17	21%
Barnet	40 (37)	38 (34)	108	72%	41	28%
Bexley	42 (39)	40 (37)	86	88%	12	12%
Brent	36 (32)	34 (31)	129	73%	47	27%
Bromley	42 (40)	40 (38)	111	78%	32	22%
Camden	44 (40)	42 (37)	62	74%	22	26%
Central London	37 (36)	34 (33)	83	87%	12	13%
City & Hackney	39 (39)	38 (37)	71	79%	19	21%
Croydon	37 (36)	34 (33)	108	77%	33	23%
Ealing	39 (35)	35 (29)	134	79%	35	21%
Enfield	39 (35)	37 (33)	120	78%	33	22%
Greenwich	43 (39)	41 (36)	77	81%	18	19%
Hammersmith & Fulham	35 (33)	33 (29)	47	73%	17	27%
Haringey	38 (36)	37 (35)	81	74%	29	26%
Harrow	37 (35)	35 (33)	114	81%	26	19%
Havering	38 (34)	36 (32)	71	76%	22	24%
Hillingdon	39 (34)	31 (30)	158	81%	37	19%
Hounslow	39 (37)	35 (34)	84	79%	23	21%
Islington	41 (37)	38 (35)	68	76%	21	24%
Kingston	38 (36)	34 (31)	42	86%	7	14%
Lambeth	41 (36)	39 (35)	83	80%	21	20%
Lewisham	42 (38)	39 (36)	77	78%	22	22%
Merton	41 (36)	40 (35)	50	77%	15	23%
Newham	41 (37)	39 (36)	91	81%	21	19%
Redbridge	39 (37)	37 (35)	80	78%	22	22%
Richmond	39 (33)	37 (31)	55	72%	21	28%
Southwark	36 (34)	34 (33)	70	80%	18	20%
Sutton	34 (31)	31 (30)	62	74%	22	26%
Tower Hamlets	40 (38)	37 (35)	80	72%	31	28%
Waltham Forest	38 (36)	36 (33)	83	86%	14	14%
Wandsworth	38 (36)	37 (34)	69	70%	29	30%
West London	37 (33)	34 (31)	79	85%	14	15%

Appendix 2: On-scene times and care bundle provision by LAS Group Station

LAS Group Station	Mean (median) on-scene times, minutes		Complete Care Bundle delivered			
	Arrival of first vehicle	Arrival of first conveying vehicle	Yes/ Exception		No	
			n	%	n	%
Homerton	40 (38)	37 (36)	118	71%	49	29%
Newham	40 (37)	37 (34)	208	80%	53	20%
Romford	39 (36)	37 (34)	156	78%	43	22%
North East Sector	39 (37)	37 (35)	482	77%	145	23%
Camden	41 (39)	38 (36)	142	79%	38	21%
Edmonton	39 (35)	37 (33)	187	82%	40	18%
Friern Barnet	39 (35)	37 (34)	99	71%	41	29%
North Central Sector	40 (37)	37 (35)	428	78%	119	22%
Brent	37 (34)	35 (32)	287	79%	77	21%
Fulham	38 (34)	35 (32)	119	76%	38	24%
Hanwell	40 (36)	34 (30)	192	82%	43	18%
Hillingdon	37 (35)	31 (30)	122	80%	30	20%
Westminster	37 (34)	36 (31)	60	80%	15	20%
North West Sector	38 (35)	34 (31)	780	79%	203	21%
Bromley	42 (39)	39 (36)	142	78%	40	22%
Deptford	39 (36)	37 (35)	222	80%	57	20%
Greenwich	42 (39)	40 (37)	151	84%	28	16%
South East Sector	41 (37)	38 (36)	515	81%	125	19%
Croydon	38 (35)	35 (32)	91	81%	22	19%
New Malden	38 (37)	36 (32)	54	71%	22	29%
St Helier	38 (35)	35 (32)	90	72%	35	28%
Wimbledon	37 (34)	35 (32)	93	74%	32	26%
South West Sector	38 (35)	35 (32)	328	75%	111	25%
PAS & VAS	41 (37)	37 (33)	34	61%	22	39%
Other LAS[†]	38 (35)	36 (33)	129	82%	28	18%

[†] *Includes Hazardous Area Response, Special Events, Tactical Response Units and Training stations.*

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	28 January 2020			
Report title:	Regulation 28; Prevention of Future Deaths Report arising from the inquests into the deaths of Xavier Thomas; Christine Archibald; James McMullan; Alexandre Pigeard; Kirsty Boden; Sébastien Bélanger; Sara Zelenak; and Ignacio Echeverria Miralles de Imperial – LAS Response			
Agenda item:	Additional report, circulated for information only			
Report Author(s):	Philippa Harding, Director of Corporate Governance			
Presented by:	Philippa Harding, Director of Corporate Governance			
History:	The Board has previously received updates on the inquests and inquiries associated with the major incidents that took place in 2017 at its informal meeting on 30 October 2018 (ref: TBD/18/15) and at its meeting on 26 November 2019 (ref: TB/19/84) and approved the Trust's formal response to the Chief Coroner's report on the London Bridge Inquests in correspondence (ref: TBC/19/07)			
Status:	☒	**Assurance**	☒	**Discussion**
	☐	**Decision**	☐	**Information**

Background / Purpose:

This report provides the Board with the final version of the Trust's response to the Chief Coroner's Regulation 28; Prevention of Future Deaths Report arising from the inquests into the deaths of Xavier Thomas; Christine Archibald; James McMullan; Alexandre Pigeard; Kirsty Boden; Sébastien Bélanger; Sara Zelenak; and Ignacio Echeverria Miralles de Imperial. It also provides the Board with information about the action plan that has been put in place to ensure that the undertakings provided in this response are carried out. Responsibility for tracking progress against this action plan will rest with the Serious Incident Assurance and Learning Group (SIALG)/

Recommendation(s):

The Board is asked to note the information provided within the report.

Links to Board Assurance Framework (BAF) and key risks:

Whilst there are no links to the Board Assurance Framework, the risks to staff welfare and potential reputational impact of these inquests and inquiries should be noted.

Please indicate which Board Assurance Framework (BAF) risk it relates to:

Clinical and Quality	☐
Performance	☐
Financial	☐

Workforce	☐
Governance and Well-led	☐
Reputation	☐
Other	☐
This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

London Bridge Attack 2017

1. Two inquests were held; one for the victims of the attack and one for the attackers. The inquest touching the death of the attackers concluded on 16 July 2019. The jury returned a unanimous determination of lawful killing. The inquest for the victims of the attack concluded on 28 June 2019. The Chief Coroner determined that all eight victims were unlawfully killed.

2. The Chief Coroner issued a PFD report, which included the following matters of concern identified specifically in relation to the LAS during the course of the inquests:

    2.1. (MC13 – Addressed to the LAS, Metropolitan Police Service (MPS) and City of London Police (CoLP)): "The evidence in these Inquests gave rise to concerns that procedures for emergency response to marauding terrorist attacks were inflexible. In particular, the evidence suggested that large areas could be designated hot and warm zones for long periods and formally placed out of bounds to most ambulance and paramedic staff. This feature of the procedures gave rise to a risk of delay in getting medical help to casualties. While this lack of flexibility has apparently been addressed in the revised Joint Operating Principles, I suggest that procedures generally be reviewed to ensure that they accord with the requirements of speed and flexibility of response which appear to be recognised in that document. I also suggest that training exercises be devised which address demanding situations with features such as (a) hot and warm zones of uncertain extent; (b) a need for re-assessment of hot and warm zones; and (c) a need to locate and assist casualties in dangerous areas."
    2.2. (MC14 – Addressed to LAS): "The evidence in these Inquests highlighted the importance of identifying the location of casualties at an early stage in a marauding terrorist attack. I suggest that LAS review its guidance documents and training exercises to ensure that they stress this point and indicate practical means of locating casualties (e.g. from information in emergency call records)."
    2.3. (MC17 – Addressed to the LAS, MPS and CoLP): "I suggest that consideration be given to introducing / improving technical measures to assist in identifying the exact locations of emergency services personnel so that they can be communicated reliably to other first responders."
    2.4. (MC18 – Addressed to the MPS and LAS): "The evidence at the Inquests indicated that life-saving efforts of the emergency services, especially in major incidents, are improved by better communications between them. Given the challenges of communications in the early stages of incidents, I suggest that consideration be given (including through the Blue Light Collaboration Programme) to the possibility of having a small number of LAS and London Fire Brigade staff stationed in the MPS control room at all times."

3. Other matters of concern that might have an impact upon the LAS, but to which it is not required to respond:

    3.1. (MC15 – Addressed to the MPS and CoLP): "I suggest that the emergency services give serious consideration to enhancing first aid capabilities and equipment of either police officers generally or groups of officers (e.g. firearms officers or officers designated for advanced medical aid training). This should include consideration of training some officers in advanced life-saving procedures analogous to battlefield medicine. It should also include considering (a) wider provision of equipment such as tourniquets and "stop the bleed" kits and (b) the inclusion of more spare equipment in officers' vehicles."
    3.2. (MC16 – Addressed to the MPS and CoLP): "The evidence in the Inquests raised a concern that there will often be communications difficulties in the early stages of a major incident, including difficulties resulting from multiple officers attempting to make urgent radio transmissions at the same time. In the ongoing work of reviewing

and improving communications technology to address these difficulties, consideration should be given to whether it may be possible for control room staff to isolate and record messages so that they can be listened to separately."

4. In addition to his concerns relating to the emergency response to terrorist attacks, the Chief Coroner also identified to matters of concern in relation to protective security; counter-terrorism investigations; measures for preventing "vehicle as weapon" attacks with rental vehicles; marine policing on the Thames and searches for casualties in the river; and the City of London Police.

5. The Board approved the Trust's formal response to the Chief Coroner (attached as Annex A to this report) in correspondence in order to ensure that it was provided in line with the required timeframe.

6. An action plan has been established, for review by the Trust's Serious Incident Assurance and Learning Group. This is attached at annex B to this report.

Philippa Harding
Director of Corporate Governance

London Ambulance Service NHS
NHS Trust

Legal Services
Headquarters
220 Waterloo Road
London
SE1 8SD

Tel: 0207 783 2001
Fax: 0207 783 2009

www.londonambulance.nhs.uk

Her Majesty's Chief Coroner Mark Lucraft
Room C09
The Royal Courts of Justice
London
WC2A 2LL

And by email: chiefcoronersoffice@judiciary.uk

9th January 2020

Dear Sir

Regulation 28; Prevention of Future Deaths Report arising from the inquests into the deaths of Xavier Thomas; Christine Archibald; James McMullan; Alexandre Pigeard; Kirsty Boden; Sébastien Bélanger; Sara Zelenak; and Ignacio Echeverria Miralles de Imperial.

Thank you for your Regulation 28 Report dated 1st November 2019 setting out matters of concern regarding the circumstances creating a risk of future deaths.

I would like to begin by again expressing sincere condolences on my own behalf and on behalf of the LAS Board to the families of the eight deceased victims, Xavier Thomas; Christine Archibald; James McMullan; Alexandre Pigeard; Kirsty Boden; Sébastien Bélanger; Sara Zelenak; and Ignacio Echeverria Miralles de Imperial.

I would like to also express my thanks for the rigorous investigation into the facts and evidence that was presented at the inquests.

I hope that this reply will be helpful in detailing the consideration given and actions taken to demonstrate how the matters of concern have been addressed and the ongoing work to make improvements within the London Ambulance Service NHS Trust (LAS). It remains our intention to continue working with our fellow emergency service partners both locally and on a national level on the issues raised.

I will address your concerns, as directed to the LAS as follows:

MC13 – "Procedures generally be reviewed to ensure that they accord with the requirements of speed and flexibility of response..... I also suggest that training exercises be devised which address demanding situations which features such as (a) hot and warm zones of uncertain extent (b) a need for re-assessment of hot and warm zones and (c) a need to locate and assist casualties in dangerous areas."

Joint Operating Principles of the Emergency Services (JOPs)

As previously reported to you, the Joint Operating Principles of the Emergency Services (JOPs) were completely reviewed and updated in February 2019 and have now been implemented as a new first edition. This new edition JOPs is titled "Responding to a Marauding Terrorist Attack (MTA)", rather than "Marauding Terrorist Firearm Attack (MTFA)" as was the case in the 2017 edition. The new edition covers various types of attack methodology,

rather than only firearms attacks. These new JOPs also incorporate wider learning from the incidents of 2017, in that the principles are now designed to be more adaptable and flexible to allow a scalable response for varied methods of terrorist attack and include the deployment of both specialist and non-specialist responders.

With regard to the issues of the identification and flexibility of zoning, the new JOPs now include additional clarifications on each of the following specific definitions:

The **Hot Zone**; an area assessed to contain a credible and continuing threat to life, including the presence of attackers with weapons. Therefore, the hot zone will initially include both specialist and non-specialist police responders, dependent upon the nature of the threat(s) present and attack methodology. LAS resources will not proactively be deployed into this zone, unless the situation warrants an exceptional deviation from guidance.

The **Warm Zone**; an area where the attackers are not believed to be present at this time, but an identified threat remains. In the light of learning from the incidents in 2017, the response in the warm zone will now vary depending on the attack methodology, the threat, and measures in place to mitigate that threat. Therefore, multi-agency responders in the warm zone can now include a combination of both specialist and non-specialist responders. Such changes in the JOPs enable the LAS to initiate a more flexible and dynamic approach at an incident, thus achieving a greater speed of deployment and increasing the availability of clinicians to treat patients.

In addition to this, the principles further state that the availability of armed police officers to escort responders is not guaranteed and should not delay responder deployment, again allowing the LAS greater flexibility of response as required and as indicated by dynamic risk assessments on scene.

The **Cold Zone**; an area where no known threat exists or where appropriate control measures have been implemented. Potential control measures and their necessity will be determined by attack methodology and proximity to the hot and warm zones. Some cold zones will not require any control measures. It is expected that Forward Command Points will be established on the edge of cold and warm zones.

The updated JOPs sets out that the size, location and necessity for zones should be continuously reviewed and every effort should be made to reclassify zones to accurately reflect constantly evolving threat and risk. It specifies that zones should be no larger than absolutely necessary and their size should relate directly to the attack methodology. It provides an example where there is a firearms threat, the hot and warm zones may be considerably larger than those for an incident involving bladed weapons or a hostile vehicle attack.

The aim is to move the hot zone to warm as soon as practicable to enable the rapid deployment of responders to deliver clinical care to save life. As soon as it is confirmed that any threat has been mitigated, this information should be shared immediately with responding organisations.

National Ambulance Resilience Unit (NARU)

The National Ambulance Resilience Unit (NARU) acts as a central support unit for all UK ambulance services, to ensure that they as a whole can respond to a variety of hazardous and challenging incidents in the safest and most effective way possible. NARU's key role is to maintain and develop the high standards expected of all the NHS ambulance service's specialist interoperable capabilities so they are always high quality and always fit for purpose.

Maintaining contract standards, ensuring safe systems of work, training and equipping specialist operational staff from each service so that they have the right tools, knowledge and attitude to be able to enter challenging and hazardous situations with the confidence and ability to save lives (while mitigating the risks to their own safety) is key to NARU's work. Accordingly, NARU works closely with a range of stakeholders to support the national development of Emergency Preparedness, Resilience and Response (EPRR) related policy.

Given NARU's role the LAS continues to work closely with it to develop guidance and standard operating procedures to support the deployment of staff into appropriate zones at future incidents. This will ensure the broadest experience and input is secured for this work. NARU will be providing greater clarity on the expectations of how and when Ambulance responders should deploy into the warm zone of incidents. This will be in the next edition of the JOPs, subject to the agreement of all relevant agencies. It remains the LAS' expectation that its staff will receive support from Police and Fire Service responders under the Joint Emergency Services Interoperability Principles (JESIP) when operating in a warm zone. NARU has representation on the JESIP MTA JOPs working group who will ensure these issues on behalf of ambulance services continue to be represented and reviewed.

In line with NARU responsibility for maintaining contractual standards it has agreed to undertake a formal review of the national contract standards for ambulance services' MTA interoperable capability. An audit of the current national MTA capability has been completed, which included a compliance assessment for every Ambulance Trust in England, including the LAS. Both the findings of this audit and the recommendations in the Regulation 28 Report will inform NARU's review of the MTA capability contract standards. The updated MTA contract standards will be in place for the new commissioning period (start of the new financial year 2020).

Furthermore, NARU is also undertaking a formal review of the national MTA Standard Operating Procedures (and corresponding generic rescue plan, generic operational risk assessment, equipment data sheets and training information sheets including core competencies) which enable the local implementation of the JOPs, with the intention to include further clarification of warm zone responders and deployments. The formal process for making changes to national provisions is clearly defined within the NARU 'National Provisions for Interoperable Capabilities' and will be followed.

NARU has confirmed that, once updated, these provisions will become mandatory for all NHS Ambulance commanders, HART and MTA responders. They will be required to be included on all subsequent MTA training courses (national and local) and they will be communicated to all relevant responders via the existing Proclus Standard Operating Procedures platform. The updated MTA standard operating procedures and safe system of work provisions will be in place by July 2020, subject to NARU's workplan being agreed by NHS England.

LAS policies and procedures

In order to embed the changes in the February 2019 JOPs, the LAS training and exercise packages, action cards and procedures were reviewed. March 2019. These will be undergoing a further review following the detail of your Regulation 28 Report and following the formal review by NARU. This further review will be complete by September 2020.

Training of LAS staff

Upon implementation of the updated JOPs in February 2019, the LAS commenced a 10 week specialist training programme for specialist responders and commanders (Hazardous Area Response Team (HART), Tactical Response Unit (TRU) and commanders) to ensure they are all fully up to date with the changes and new

provisions within the JOPs. This training, which is the consolidation of the theoretical learning form the JOPs and its practical application in a multi-agency scenario setting includes classroom based learning, table top exercises and physical MTA live exercises conducted on a multi-agency basis (alongside the Metropolitan Police Service (MPS) and London Fire Brigade (LFB)). Currently, 100% of TRU staff, 94% of HART staff and 100% of commanders have completed the training. In addition to specialist teams and commanders, the LAS is also training front line (non-specialist) staff through its annual Core Skills Refresher (CSR) training programme, identified as CSR 2019.3. This particular module started on 1st December 2019 and will run through to 31st March 2020.

Alongside classroom based learning, the LAS also continues to instigate and engage in multi-agency MTA training exercises with both specialist and non-specialist responders, including the 'Yellow Penguin' Exercise which took place at Chessington on 6th March 2019, Exercise 'Red Botham' at Lords cricket ground on 30th March 2019 and Exercise 'Eleanor' on 28th October 2019. In addition, the LAS has undertaken further live exercises to test particular elements of the JOPs. An example of this is the 'Autumn Falls' Exercise which specifically included the identification and response to hidden casualties. This took place on 29th September 2019 and was a large scale Chemical Biological Radioactive and Nuclear (CBRN) training exercise.

Exercise 'Autumn Falls' was located at a sporting stadium; information relating casualty locations within the stadium was fed into the LAS Specialist Operations Centre (SOC) and venue control room to test the information flow between these areas and the exercise commanders and responders on the ground, to ensure that information was received and acted on, finding the exercise casualties hidden within the stadium. The exercise debrief is currently being finalised, and by the end of January 2020 the relevant SOC action cards will be updated to ensure that learning is incorporated in LAS response to incidents. Further information can be found below regarding the location and assistance of casualties.

In addition to multi-agency training exercises, the LAS is providing a teaching session to MPS staff on their tactical firearms commander course, which explains the LAS response to MTA incidents and the principles of casualty management from an LAS perspective. The session covers the LAS duty of care to patients, the incident response structure and the LAS' pre-determined response to a MTA or major incident. It also includes information relating to casualty collection points, the purpose and benefit of these and how the MPS and LAS work jointly during a major incident. It stresses the importance of recognising and understanding the use and process of casualty collection points and how patients can be brought directly to them for medical treatment.

Effective joint decision making is crucial for multi-agency working during an MTA or major incident and the session also covers best practice in this respect and sets out examples of how working well together will increase the speed of deployment of ambulance resources to provide life-saving intervention.

The LAS commends the actions of police officers who worked bravely and tirelessly on scene to treat the many injured patients and the LAS fully supports the work being undertaken to expand the police first aid training and provision of equipment, recognising the benefit this will bring to those officers who may arrive first on scene.

MC14 – "the LAS review its guidance documents and training exercises to ensure that they stress this point and indicate practical means of locating casualties (e.g. from information in emergency call records)"

<u>Locating and assisting casualties – changes to LAS guidance and procedures as a result of training exercises</u>

The location and assistance of casualties in dangerous areas has been a clear area of focus for all agencies responding to an MTA, as evidenced by the "Autumn Falls" Exercise and training programmes referenced above.

In response to the issues raised by the 2017 incidents and the learning from the 'Autumn Falls' Exercise, when faced with a MTA or major incident, the LAS has decided to designate specific roles SOC Manager (to ensure the information is considered and actioned), a Critical Loggist and a SOC Allocator) within its control room to undertake the task of identification and recording of casualty locations to prevent any oversight. Those within these roles are tasked with ensuring that identification of casualty locations is prioritised, with a designated person responsible for constantly monitoring, reviewing and linking up information coming from members of the public via 999 calls, the MPS CAD link, ES5 (emergency services radio communication channel) and the call log so that it can be actioned. By operating in this manner the LAS can mitigate against a single point of failure and in smaller incidents where not all roles are filled, at least one of these roles will be present.

All patient information received will be cross referenced to ensure that a full picture of patients' injuries and locations is captured. Action Cards will also detail the process of passing the information to the Ambulance Commander at the Forward Command Point. Once in receipt of patient location information, the commander at the Forward Command Point will coordinate extraction of the patient. It is detailed in the JOPs that this type of information will form part of the commander's casualty management plan.

Control room staff will be updated in the use of this process so that, by March 2020, there will always be a staff member on shift on a 24/7 basis with the capability of undertaking these roles. Training for control room staff will be provided via a bulletin for Emergency Operations Centre (EOC) staff with the updated Action Cards. It is also currently being explored whether a session can be incorporated into the EOC Core Skills Refresher training for the coming year.

MC17 – "consideration be given to introducing/ improving technical measures to assist in identifying the exact locations of emergency services personnel so that they can be communicated reliably to other first responders"

NARU is nationally responsible for the development and introduction/improvement of technical measures to assist in the identification of casualties and emergency service responders during an MTA. Its aim is to ensure that a nationally-appropriate solution is adopted, which can be accessible by all emergency services (fire, police and ambulance). In light of its experience in responding to these and other major incidents, the LAS has been asked by NARU to take the lead in the practical assessment of these technical measures. Over the course of 2020, the LAS will therefore be working to review the technical solutions currently available, including those which are already in use by different emergency services. As the successful roll out of these technical solutions will be dependent on their interoperability with current or any new Computer Aided Dispatch (CAD) systems, it is not anticipated that a solution will be implemented before 2023.

MC18 – "consideration be given (including through the Blue Light Collaboration Programme) to the possibility of having a small number of LAS and London Fire Brigade staff stationed in the MPS control room at all times"

The LAS continues to work together with the MPS and the LFB through the Blue Collaboration Programme to explore all possibilities for improved joint-working and communication, including the implications of co-locating a small number of LAS and LFB staff in the MPS control room on a permanent basis.

A table top exercise to explore co-location of some staff in the MPS control room has already been completed in November 2019. The involved operational staff from LFB, LAS and MPS. The team examined calls during a six-hour late duty in October, to see what effect the immediate triaging of calls may have had on deployments for each of the services during this period.

A further live trial is planned for seven days in February 2020. This will see a member of LAS staff based in the MPS control room with a member of the LFB, 24 hours a day. The focus on this test of concept is on timely and accurate situational information sharing. The outcome of this trial will be analysed and a recommendation based upon the results will be considered for approval by the Autumn of 2020.

Finally, I very much hope this response helps in setting out the ongoing work that the LAS is engaged with to ensure front line and command personnel are fully up date and trained in the latest JOPs, when faced with a major incident or MTA in the future. Learning and development from Serious Incidents are never a finished task and the LAS will continue to work with its emergency service partners to promote best practice in sharing information and collaborating as part of a multi-agency approach. The LAS is committed to continuing its local and national work in its ongoing effort to perform at its best for all patients, whenever they need it.

The LAS Board takes its responsibilities very seriously and has emphasised the importance of ensuring that the organisation's ongoing capability to respond to MTA and other major incidents remains a matter of focus. To this end it has increased its visibility of the HART and TRU teams through visits to these teams and enhanced reporting on their readiness and performance. A lead Non-Executive Director for EPRR issues has been identified and the Board will be receiving regular updates on the progress of the actions set out in this response.

My thoughts and those of my colleagues at LAS remain with the families of the victims.

Yours sincerely

Garrett Emmerson

Chief Executive, London Ambulance Service NHS Trust

LONDON BRIDGE PFD RESPONSE - ACTION TRACKER				
Action	**Owner**	**Due for completion**	**Legal to review progress**	**Evidence of completion (to be attached to Datix)**
MTA contract standard will be in place for the new commissioning period (start of the new financial year 2020)	EPRR - Tracy Porter /Pauline Cramner	01/04/2020	02/03/2020	
The update MTA standard operating procedures and safe system of work provisions will be in place by July 2020, subject to NARU's workplan being agreed by NHSE.	EPRR - Liam Lehane/Pauline Cramner	31/07/2020	30/03/2020 30/06/2020	
JOPs, training and exercise packages, action cards and procedures to further review by September 2020.	EPRR - Tracy Porter /Pauline Cramner.	30/09/2020	30/03/2020 30/06/2020 31/08/2020	
10 week specialist training programme and CSR 2019.3 to be completed by 31/03/2020	EPRR -Tracy Porter and Training and Education - Ian Bullamore/Tina Ivanov	31/03/2020	02/03/2020	
Autumn Falls exercise debrief to be finalised by 31/01/2020	EPRR Tracy Porter/Pauline Cramner	31/01/2020	24/01/2020	
Update of Control Room staff on SOC Manager, Critical Loggist and SOC Allocator and processes to be in place	EOC - Athar Khan EPRR - Tracy Porter/Kamlesh Chauhan	31/03/2020	02/03/2020	
Review of technical solutions with NARU for identifying casualties and responders, taking place throughout 2020	EPRR Liam Lehane/Pauline Cramner	31/03/2021	30/03/2020 30/09/2020 03/01/2021	
Live trial in February 2020 of LAS staff based in MPS control room for 24 hrs. Results to be considered for approval by autumn 2020.	Khadir Meer/Pauline Cramner and Athar Khan	30/10/2020	30/03/2020 30/06/2020 30/09/2020	

London Ambulance Service NHS Trust

Report to:	**Audit Committee**			
Date of meeting:	05 November 2019			
Report title:	Annual Review of Corporate Governance			
Agenda item:	11			
Report Author(s):	Philippa Harding, Director of Corporate Governance			
Presented by:	Philippa Harding, Director of Corporate Governance			
History:	N/A			
Status:	☐	**Assurance**	☐	**Discussion**
	☒	**Decision**	☐	**Information**

Background / Purpose:

This report sets out the proposed framework to be used in reviewing the Trust's corporate governance structures and their support of the achievement of its objectives. The outcome of this review will form the basis of any recommended changes to the framework, for consideration by the Trust Board. This review of the Trust's corporate governance should be undertaken on an annual basis in the final quarter of the financial year, for consideration by the Board at its meeting in March, which can then subsequently inform the draft Annual Governance Statement that will first be considered by the Audit Committee in April

Recommendation(s):

The Audit Committee is asked to comment on the proposed framework for the corporate governance review and confirm it is content with it.

Links to Board Assurance Framework (BAF) and key risks:

Failure to ensure that the Trust has appropriate corporate governance arrangements could result in inappropriate decision-making.

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	☐
Performance	☐
Financial	☐
Workforce	☐
Governance and Well-led	☒
Reputation	☐
Other	☐

This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	☒
Ensuring staff are valued, respected and engaged	☒
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

Annual Review of Corporate Governance

1. It is good practice to undertake an annual review of the Trust's corporate governance structures and how they support the achievement of its objectives. This paper sets out the proposed framework for such a review, its objectives and the assurances that it will provide. It is intended that the outcome of the review will be presented to the Board at its meeting on Tuesday 31 March 2020, together with any recommendations arising from it. It will then subsequently inform the drafting of the Trust's Annual Governance Statement, which will be presented to the Audit Committee at its meeting in April 2020. In line with best practice, as it is nearly three years since the Board commissioned an external evaluation of its effectiveness, it is proposed that this internal review is undertaken alongside an external review of Board effectiveness. This external review is in the process of being commissioned and is expected to take place before the end of 2019/20.

2. This paper sets out the proposed approach for the internal corporate governance review.

Corporate Governance Review Objectives

3. The review is proposed to have the same objectives as in 2018/19:

a) Objective 1 – confirm that effective corporate governance arrangements are embedded across the organisation

Assurance	**Can be evidenced by**
Code of corporate governance adopted	1. Principles of relevant code of corporate governance embedded within corporate governance frameworks and processes 2. Awareness of the relevant code of corporate governance
Review and monitoring arrangements in place	1. Corporate governance arrangements are regularly reviewed 2. There are clear arrangements for monitoring compliance with corporate governance frameworks and processes 3. An annual report on compliance with corporate governance best practice is reviewed by non-executives 4. Regular internal audit reviews of corporate governance frameworks and processes take place 5. Any corporate governance weaknesses are identified and an action plan is prepared to address them
Committee charged with governance responsibilities	1. Responsibility for overseeing corporate governance has been formally delegated to an appropriate committee 2. Committee terms of reference clearly demonstrating responsibility for corporate governance issues have been approved by the Board 3. Terms of reference are sufficiently comprehensive to ensure that all appropriate aspects of corporate governance are covered 4. Agenda and minutes from the committee charged with corporate governance responsibility indicate that the responsibility is being discharged adequately

Assurance	Can be evidenced by
Governance advice and training available to key executives and non-executives	1. Induction training for key new executive and all non-executives incorporates suitable coverage on corporate governance issues according to responsibilities 2. Ongoing awareness training is provided as appropriate to key staff and all members to ensure that there is an appropriate awareness of the organisation's corporate governance frameworks and processes

b) Objective 2 – identify principal risks to achievement of objectives

Assurance	Can be evidenced by
There is a written strategy and policy in place for managing risk which: - Has been formally approved at board level - Is reviewed on a regular basis - Has been communicated to all relevant staff	1. Existence of approved strategy and policy document 2. Evidence of formal approval (e.g. board/committee minutes) 3. Evidence of formal review (e.g. board/committee minutes, document version number and date) 4. Evidence of communication strategy, possibly covered in strategy document 5. Examples of dissemination e.g. induction, briefings, awareness sessions, policy and strategy published on intranet, strategic diagnostic questionnaire results
Clear structures and processes for risk management which are successfully implemented and: - Board sees risk management as a priority and support it by personal interest and input - Decision making considers risk - A senior manager has been appointed to "champion" risk management - Roles and responsibilities for risk management have been defined - Risk management systems are subject to independent assessment - Risk management is considered in the annual business planning process	1. Board/committee minutes 2. Internal audit reports and external audit comments on risk management system 3. Annual business plans 4. Link between internal audit and risk management functions is clearly defined in terms of reference of internal audit 5. Responsibility for risk management function is set at appropriate senior level 6. Committee reports setting out options for change include an appropriate risk assessment, including the 'no change' option 7. The corporate business plan and financial plan assess risks as appropriate and in particular take account of new and emerging risks facing the organisation
The organisation has developed a corporate approach to the identification and evaluation of risk which is understood by all staff	1. Systematic procedures for risk identification and evaluation have been agreed and published in a policy document and are consistently applied across all business units and partnerships

Assurance	Can be evidenced by
	2. Examples of dissemination e.g. induction, briefings, awareness sessions, strategic diagnostic questionnaire results
The organisation has well defined procedures for recording and reporting risk	1. Evidenced by review of risk management strategy and policy 2. Examination of corporate and partnership risk registers 3. Key risk indicators have been determined and there is evidence of monitoring against these risks 4. Evidence of regular and frequent reporting of risk to political and management board level 5. Evidence of risk based auditing being carried out 6. Evidence of risks not properly addressed identified in internal audit reports etc being fed into the risk management process 7. Environmental scanning reports are fed into the risk management process so as to identify new and emerging risks
The organisation has developed a programme of risk management training for relevant staff	1. Training programme for risk management 2. Training needs analysis (both specialist staff development and general awareness) 3. Regular newsletter or other means of communicating risk management issues to staff 4. Induction programme includes risk 5. management 6. Appropriate responsibilities for risk management incorporated into job descriptions and appraisals
The committee responsible for risk management adds value to the risk management process by: - Advising and supporting management team on risk strategies - Identifying areas of overlapping risk - Driving new risk management initiatives - Communicating risk management and sharing good practice - Providing and reviewing risk management training - Regularly reviewing the risk register(s) - Coordinating the results for risk reporting	1. Risk management committee's terms of reference 2. Minutes of corporate risk management board 3. Reports to corporate management team 4. Low incidence of avoidable risk events occurring

Assurance	Can be evidenced by
Managers are accountable for managing their risks	1. Evidence of manager involvement in risk identification and analysis process 2. Risk owners detailed in corporate /departmental risk register(s) 3. Risk owners assigned in relation to key partnerships 4. Job descriptions of managers outline their risk management responsibilities 5. Evidence of (at least) annual review of risk at service/operational levels and of partnership risks 6. Analysis of completed control and risk self-assessment questionnaires
Risk management is embedded throughout the organisation	1. Evidence of a general risk management culture at all levels 2. Risk management training programme 3. Evidence of managers involvement in risk management aspects of business planning 4. Results of strategic diagnostic survey to ascertain the extent to which risk management is understood by each category of officer (senior management, operational managers etc) and members

c) Objective 3: Identify and evaluate key controls to manage principal risks

Example of assurance	Evidenced by
There are written financial regulations in place which have been formally approved, regularly reviewed and widely communicated to all relevant staff.	1. Financial regulations and instructions exist & are reviewed & updated regularly 2. Evidence of formal approval 3. Examples of dissemination e.g. induction, briefings, awareness sessions, accessible in finance manuals and/or on intranet site 4. Reports to audit committee or equivalent confirming compliance or identifying extent of non-compliance with regulations and instructions
There is a whistle blowing policy in place which has been formally approved, regularly reviewed and widely communicated to all relevant staff	1. Whistle blowing policy exists and has been reviewed and updated regularly. 2. Evidence of formal approval 3. Examples of communication and dissemination e.g. induction, briefings, awareness sessions, accessible on website and intranet site 4. Evidence of effectiveness of policy (e.g. reports on incidence of usage, evidence on annual declarations on fraud)
There is a counter fraud and corruption policy in	1. Counter fraud and corruption policy exists and has been reviewed and updated regularly 2. Evidence of formal approval

Example of assurance	Evidenced by
place which has been formally approved, regularly reviewed and widely communicated to all relevant staff	3. Examples of dissemination (briefings, induction, awareness sessions, accessible on website and intranet site) 4. Evidence of effectiveness of policy (e.g. reports on identified frauds; annual AF70 returns to Audit Commission, reports on results of National Fraud Initiatives) 5. Review of register of gifts and hospitality
There are codes of conduct in place which have been formally approved and widely communicated to all relevant staff	1. Codes of conduct have been agreed, including national schemes (e.g. police officers) 2. Evidence of formal approval 3. Examples of dissemination e.g. 4. induction, briefings, awareness sessions, accessible on intranet site
A register of interests is maintained, regularly updated and reviewed	1. Inspection of register of interests (members and staff) 2. Evidence of regular updating and review by senior officer(s)
Where a scheme of delegation has been drawn up, it has been formally approved and communicated to all relevant staff	1. Scheme of delegation incorporates adequate controls and sanctions 2. Evidence of formal approval 3. Examples of communication and dissemination e.g. induction, briefings, awareness sessions, accessible on intranet site 4. Regular reports on the operation of the scheme (e.g. compliance, budget monitoring, year-end balances)
A corporate procurement policy has been drawn up, formally approved and communicated to all relevant staff	1. Procurement policy exists and has been reviewed and updated regularly to take account of new initiatives e.g. drive towards wider consortia arrangements, shared services 2. Evidence of formal approval 3. Examples of dissemination e.g. induction, briefings, awareness sessions, accessible on intranet site 4. Evidence of effectiveness of policy (e.g. benchmarking results, best value review, internal/ external audit review)
Business/service continuity plans have been drawn up for all critical service areas and the plans: - Are subject to regular testing - Are subject to regular review	1. Current business/service continuity plans exist covering all critical service areas and are readily accessible 2. Evidence of regular testing 3. Evidence of regular review in the light 4. of the results of testing and for changes in structures, procedures, information systems, responsibilities etc
The corporate/departmental risk register(s) includes expected key controls to manage principal risks	1. Risk register sets out principal risks and sets out appropriate key controls to manage them. 2. Key controls are monitored, reviewed and updated regularly 3. Use of risk management workshops to underpin the process and review of register and key controls 4. Risk owners are assigned to manage principal risks

Example of assurance	Evidenced by
	5. Partnership risks are considered
Key risk indicators have been drawn up to track the movement of key risks and are regularly monitored and reviewed.	1. Appropriate key risk indicators are documented 2. Evidence of regular monitoring 3. Evidence of changes in risk indicators (and reasons for change) emanating from appropriate information sources (e.g. where internal audit findings are used to change the perceived level of risk)
The internal control framework is subject to regular independent assessment	1. Internal audit plans and reports 2. Annual report/opinion of Head of Internal Audit 3. External audit reports
A corporate health and safety policy has been drawn up, formally approved, is subject to regular review and has been communicated to all relevant staff	1. Health & safety policy exists and has been reviewed and updated regularly 2. Policy covers partnerships 3. Evidence of formal approval 4. Examples of dissemination e.g. induction, briefings, awareness sessions, inclusion of policy on website and intranet site 5. Evidence of effectiveness of policy e.g. number of cases investigated by Health & Safety Executive – and the number of cases proven 6. Review of number of reported incidences and 'near misses'
A corporate complaints policy/procedure has been drawn up, formally approved, communicated to all relevant staff, the public and other stakeholders is regularly reviewed	1. Complaints policy/procedure exists and has been reviewed and updated regularly 2. Procedure is compliant with all relevant statutory requirements 3. Evidence of formal approval 4. Examples of dissemination e.g. induction, briefings, awareness sessions, inclusion of policy on website and intranet site 5. Leaflets/posters highlighting complaints procedure 6. Complaints files 7. Committee reports summarising complaints dealt with analysed by outcome

d) Objective 4: Obtain assurance on the effectiveness of key controls

Example of assurance	Evidenced by
The organisation has determined appropriate internal and external sources of assurance	1. Minutes of committee at which report on assurances was considered 2. Sources of assurance are appropriate to the organisation
Appropriate key controls on which assurance is to be given have been identified and agreed	1. Briefing notes, guidance, instructions etc given to appropriate managers regarding what is expected of them

Departmental assurances are provided	1. Departmental heads sign off on adequacy of controls (i.e. provide annual governance assurance statements) 2. Supporting documentation provided by departmental heads re review and monitoring arrangements that key controls have been in operation for the period and will continue to operate until accounts signed off. 3. Structured process and standard documentation to ensure consistency of coverage and common understanding of level of assurance given. 4. Completed Control & Risk Self- Assessment questionnaires 5. Annual governance assurance statements evaluated by officer team or committee charged with the responsibility of preparing the AGS. Evaluation to include 'reality checking' of sample of assurance statements
Internal Audit Arrangements	1. Reports of Head of Internal Audit to audit committee or equivalent throughout the year 2. Annual report of Head of Internal Audit, including opinion on internal control and risk management framework
Corporate Governance Arrangements	1. Annual corporate governance assurance statement 2. Internal or external audit review of corporate governance arrangements 3. Monitoring reports to committee on delivery of action plans in response to reviews of corporate governance
Performance monitoring arrangements	1. Annual and in-year reports on delivery of key performance indicators by internal and/or external review agencies

4. Is the Audit Committee content with the proposed objectives of the Corporate Governance Review and the assurances that will be provided as a result?

Philippa Harding
Director of Corporate Governance